Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Annual Business Plan 2014-2015

June 2014

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Hamilton Niagara Haldimand Brant Local Health Integration Network
Annual Business Plan 2014-15

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June 12, 2014

Ms. Nancy Naylor
Assistant Deputy Minister
Health System Accountability and Performance Division
Hepburn Block
5th Floor
80 Grosvenor St
Toronto ON M7A1R3

Dear Ms. Naylor:

Re: Hamilton Niagara Haldimand Brant Local Health Integration Network - Annual Business Plan, 2014-15

Our 2014-15 Annual Business Plan (ABP) represents the second year of our three-year Integrated Health Service Plan (IHSP), based on our Strategic Health System Plan (SHSP), approved by the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) Board of Directors (Board) in December 2012. The 2014-15 ABP follows the guidelines provided by the Ministry of Health and Long-Term Care (ministry), focusing on goals and action plans relating to system change and outcomes.

With a view to building on the Minister of Health and Long-Term Care (Minister's) Action Plan, and the LHIN's collective provincial priorities, the overall aim of the HNHB LHIN over the course of the next several years, is to continue to dramatically improve the patient experience through quality, integration and value. Our three key strategic directions, flowing from this aim, are:

1. Dramatically improving the patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHIN by becoming Health System Commissioners.

In setting our aim to "dramatically" improve the patient experience, the HNHB LHIN Board is signalling its desire to see bold and urgent action on the transformation agenda.

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Ms. Nancy Naylor

These strategic directions are defined in terms of specific goals and action steps, with a particular focus on 2014-15, being the second operating year of our current IHSP. Action plans for each of the priorities identified in the IHSP are presented, following the template provided by the ministry and incorporating ministry comments on the draft ABP. The ABP also outlines proposed HNHB LHIN staffing and operations, following the templates provided by the ministry.

We are excited about the potential we see represented by these strategic directions and action plans, and look forward to ministry approval before posting our ABP.

Sincerely,

Michael P. Shea
Board Chair

c. Kathryn McCulloch, Director, LHIN Liaison Branch
Donna Cripps, Chief Executive Officer, HNHB LHIN

2. Narrative Context:

The Annual Business Plan (ABP) is a key component of the Ministry of Health and Long-Term Care (Ministry) and Local Health Integration Network (LHIN) accountability framework. It operationalizes the Integrated Health Service Plan (IHSP) by providing annual goals and action plans for each IHSP priority. The IHSP is a three year plan for the LHIN, and this ABP (2014-15) represents the second year of the LHIN's third IHSP.

Last year, in preparation for the IHSP, the Hamilton Niagara Haldimand Brant (HNHB) LHIN undertook a strategic planning process to identify those key directions which, implemented together, will transform the system.

The ABP is not intended to repeat detailed information provided in other LHIN planning/reporting documents. It identifies actions and intended changes planned for the upcoming fiscal year. The information below summarizes the LHIN mandate and the local health system in which the LHIN operates. A more complete discussion can be found in the IHSP and the Strategic Health System Plan (SHSP).

2a. Mandate and Strategic Directions

Ontario's 14 LHINs have a mandate to plan, fund and integrate the local health care system.

The HNHB LHINs SHSP, approved by the Board of Directors (Board) in December 2012, recognizes the need for health system transformation to achieve its vision of, "a health care system that keeps people healthy, gets them good care when they are sick, and will be there for our children and grandchildren". The vision from the Minister of Health and Long-Term Care (Minister's) Action Plan: ***"To make Ontario the healthiest place in North America to grow up and grow old"***, has strengthened the commitment to transformation.

With a view to building on the Minister's directions, momentum from Don Drummond's "The Commission on the Reform of Ontario's Public Services", and the LHIN's provincial priorities, the HNHB LHIN engaged PricewaterhouseCoopers (PwC) to support them in the development of a strategic plan. To emphasize that the SHSP was not a plan to plan, but a plan for action, the project was titled: **ACTION – A Call To IntegratiON Now**. The intent of the SHSP was to build an evidence-based, integrated, and person-centred health care system.

The overall aim of the HNHB LHIN, over the course of the current three year period, is to dramatically improve the patient experience through quality, integration and value.

Our three key strategic directions, flowing from this aim:

1. Dramatically improving patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHIN to become Health System Commissioners.

These strategic directions are further defined in terms of specific goals and action steps, which form the basis of the implementation plan over the coming three years. The implementation plan is further detailed through the LHIN's ABP process. As 2014-15 represents Year 2 of the IHSP, many of the goals and strategies remain in place, building on the successes of Year 1.

2b. Overview of Agencies' Current and Forthcoming Programs/Activities

The HNHB LHIN allocates approximately $2.8 billion to programs and services offered through Health Service Providers (HSPs). The LHIN holds 192 accountability agreements with these providers (96 M-SAA, 86 L-SAA and 9 H-SAA).

These agreements describe the range and scope of services provided, LHIN funding resources required to sustain services, and expected outcomes.

All organizations are guided by the IHSP priorities for health system improvement. Over the past several years, HSPs have been working with the LHIN to improve patient flow, integrate service delivery, reduce the prevalence of chronic disease, and focus on the health of the priority populations such as Seniors, Francophones and Aboriginals.

The current IHSP focuses our collective attention on improving the experience and outcomes for individuals as they go through the system, through quality improvement, system redesign, and funding/accountability reform. This ABP will outline the detailed goals and actions which will build on the successes of the past several years, and move us toward a transformed system.

2c. Assessment of Issues Facing the Agency (Environmental Scan of Opportunities and Risks)

The HNHB LHIN encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk County covering approximately 7,000 square kilometres. The HNHB LHIN is home to more than 1.4 million people with more than 70% of the population residing in the City of Hamilton and the Regional Municipality of Niagara (RMON).

The following summarizes some of the key characteristics of the local health system:

Demographics:

- The HNHB LHIN is home to about 11% of the population of Ontario and the third-largest LHIN in Ontario. The LHIN population is projected to grow 7.4% over the next ten years.[1]
- The HNHB LHIN's population is aging. The total number of people ages 65-74 years old is growing the fastest. The largest changes will be among people ages 65-74 (45.2%) and 85 or older (33.4%) over the next ten years.
- The HNHB LHIN is projected to have amongst the highest number of seniors of all LHINs in Ontario from 2011 to 2017. The number of seniors 65 plus in the HNHB LHIN is projected to grow every year over the next six years from the current more than 230,000 to over 275,000 in 2017. Over this time, the HNHB LHIN will have a higher proportion of seniors than the Ontario average, and by 2017, nearly one in five residents in the HNHB LHIN will be 65 years of age or older.[2]

Socio-Demographic Characteristics:

- The LHIN has a very diverse population. For 18% of residents, neither English nor French is their first language. Francophones, First Nations, and urban and rural Aboriginal people are recognized populations in the HNHB LHIN. Compared to Ontario, the LHIN has a lower percent of immigrants and visible minorities.
- Over 35,000 Francophones make their home in the HNHB LHIN, representing the largest French speaking population in Southern Ontario. Within the HNHB LHIN, the largest concentrations of French speaking population are in Hamilton and Welland/Port Colborne, both of which are designated municipalities under the *French Language Services Act (FLSA).*
- There are two First Nation reserves in the HNHB LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and Mississaugas of the New Credit First Nation. The total registered Aboriginal population in the LHIN is approximately 24,000 people (1.7% of the total LHIN population) with about half the population living on reserve. Non-Status, Métis, and Inuit populations are not included in these population estimates.[3]

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[1] Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

[2] Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

[3] First Nations Peoples in Ontario: A Demographic Portrait. Ministry of Health and Long-Term Care, Health System Information Management and Investment Division. Health Analytics Branch, January 2009

- The HNHB LHIN has a higher percent of lone parent families, and a lower percent of adults with post-secondary education than the Ontario average. The unemployment rate is slightly lower than the Ontario average, fluctuating over time.
- The share of economic families below the Low Income Cut-Off (LICO) in the HNHB LHIN is slightly lower at 13.8% than the Ontario average. There are also slightly lower than average education levels (both high school and university), particularly in rural areas of the LHIN.

Health Status:

- Self-reported health can show aspects of health not captured in other measures. Similar to Ontario's rates, more than 61.5% of LHIN residents rate their health as 'excellent' or 'very good'.[4] However, significantly more LHIN residents say they are limited in activities because of a physical or mental condition, or health problem, and have pain or discomfort that prevents activities.
- HNHB LHIN residents have significantly more arthritis/rheumatism compared to the province as a whole. Rates of asthma and high blood pressure are slightly, but not significantly higher than Ontario rates. Diabetes rates, on the other hand, are comparable to the province.[5] Other findings include a higher proportion of overweight/obese residents than the Ontario average, a higher incidence of arthritis, heavy drinking and injury hospitalizations (e.g. falls, motor vehicle accident), and the life expectancy is lower in the LHIN.
- Death rates reflect the overall health of the population. Lower death rates show success in preventing, detecting, treating disease, and reducing suicide. The age standardized mortality rate for the HNHB LHIN is significantly higher than the Ontario average (572 per 100,000 vs. 522 per 100,000). Heart disease, lung cancer, and stroke were the top three leading causes of death.
- Potential years of "life lost" rates are useful for measuring the number of years of "life lost" from deaths that occur "prematurely" (i.e., before age 75). Deaths, potential years of "life lost" and hospitalization rates in the HNHB LHIN are higher than provincial rates.[6]

Health Practices and Preventive Care:

- Poor health practices increase the risk of chronic disease, disability, and death. Relative to the province, more people in the HNHB LHIN smoke daily or occasionally, drink heavily, and are obese.[7]
- Preventive health care services can help detect disease early, and over the long-term can reduce illness and death. Of the selected preventive health indicators, none are significantly different from Ontario as a whole.
- Among women in the HNHB LHIN, 71.7% had a Pap smear (for cervical cancer screening) within the previous three years, 73.1% received a routine mammogram in the previous two years, and 31.7% had a flu shot in the past year.[8]

Most people get their care through their family doctors. Physicians play a key role in coordinating care and managing chronic conditions. Most people (81.3%) in the LHIN talked, either in person or by phone, with a physician in the last year. This is similar to the Ontario rate of 82.2%.[9]

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[4] Statistics Canada, Canadian Community Health Survey, 2009-10
[5] Statistics Canada, Canadian Community Health Survey, 2009-10
[6] Death, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO
[7] Statistics Canada, Canadian Community Health Survey, 2009-10
[8] Statistics Canada, Canadian Community Health Survey, 2005, 2008 and 2009-10
[9] Statistics Canada, Canadian Community Health Survey, 2009-10

3. IHSP 2013-16 Priorities:

1. Dramatically improving the patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHIN to become health system commissioners.

3.1. Dramatically improving the patient experience by embedding a culture of quality throughout the system

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by embedding a culture of quality throughout the system
IHSP Priority Description:
The HNHB LHIN will provide system-level leadership in relation to quality, and hold providers accountable for local implementation. This will be guided by a common LHIN-wide philosophy and approach to quality, targeting the reduction of variation and increasing standardization within the health system. Two key strategies will advance this goal: 1. Leveraging Service Accountability Agreements (SAA) for Quality Improvement (QI) and stakeholder engagement. 2. Building a system-wide plan for quality through the leadership of the HNHB LHIN Quality Guidance Council (QGC).
Current Status:
The HNHB LHIN's theory of QI is influenced by the work of Dr. Ross Baker and his research into high performing health systems. To advance change at scale, there must be strategy to set directions and priorities, an alignment of incentive and levers, and the capacity to build and sustain improvement. Some of the key building blocks for high-level system improvement include: • System-wide leadership by the HNHB LHIN. • Local implementation to increase engagement. • Targeting reduction of variation and increased standardization that will improve quality. • Advance and support current best practices. • Targeting areas requiring attention. • Incenting the leadership and organizational enablers to advance QI. Over the last year, the LHIN engaged HSPs across the continuum on improving our focus and efforts on system-wide QI. Our LHIN is committed to advancing the quality of care of all patients across the spectrum of HSPs. Delivering quality of care is a foundational core principle to every health care provider. This is supported by the legislative requirements set out in the *Excellent Care for All Act, 2010* (*ECFAA*). The HNHB LHIN's SHSP called for a QGC to be established and include experts from across the system to guide QI implementation. The committee is co-chaired by the Chief Executive Officers (CEOs) of the HNHB LHIN and the HNHB CCAC. The QGC members were selected to represent each health service sector and LHIN zone.

The QGC consists of membership from representatives from HSPs from all sectors across all LHIN zones. It provides expert advice on the implementation imperatives of the HNHB LHIN's Quality Strategy. The committee provides advice on the following areas:

- Governance policy and engagement.
- Balanced scorecard measures and roll-out.
- Quality Plan (QP) development, testing and implementation.
- Sustainability of QI.

At the macro-level, the QGC facilitates the development of a three year LHIN-wide QP. This plan will be phased in over three years:

Year 1 – Structure:

- LHIN-wide QP in place by April 1, 2014, to collaboratively improve a common indicator by all HSPs in all sectors.

Year 2 – Spread:

- Ensure that the common indicator is improving, approaching or surpassing target.

Year 3 – Sustain:

- Mechanisms are in place to hold the gains from the improvement efforts and learnings are shared for application to other areas.

The QGC will guide QI implementation by providing expert advice and system leadership, as well as leverage and promote individual HSP's work on their SAA requirements. The QGC will work to align HSPs to improve the quality of care across sectors and the health care system.

Key measures of success for the QGC include:

- Provide guidance on engagement and change management strategies for QI.
- Identify risks and enablers for advancing QI throughout the HNHB LHIN.
- Provide peer support to HSPs and serve as a resource in the development of quality improvement at the governance and organization level.
- Work with the HNHB LHIN to provide advice and guidance on adopting best practice improvement tools and processes from the Ministry, Health Quality Ontario (HQO) and other international bodies.
- Identify HSPs with best practices to showcase for information sharing and modeling.
- Provide special attention to system wide-strategies to improve the patient journey across the health care continuum.
- Provide special attention to initiatives and practices that improve the patient and client experience.
- Provide advice to inform the HNHB LHIN's QP.
- Provide advice on implementation of LHIN Ministry-LHIN Performance Accountability Agreement (MLPA) quality obligations.

In addition to the work of the QGC, the HNHB LHIN will facilitate the quality strategy by working with all providers to meet SAA requirements and provincial quality imperatives.

The following building blocks are the foundation of the Quality Requirement in each HNHB LHIN SAA:

- Board-approved policy on Quality.
- Balanced scorecard.
- Quality Plan to track variances and outline strategies for improvement.

These building blocks were designed to address and support the varied state of expertise in quality and the resources available currently to HSPs. Hospitals, CHCs, and the CCAC currently plan for quality through the utilization of Quality Improvement Plans (QIPs) as required by the Ministry and HQO. The LHIN works with these providers to ensure alignment between their organizational level planning with both regional and provincial priorities.

For other HSPs, more work is required to establish a strong baseline of capacity to execute quality improvement now and into the future. For these HSPs, mainly in the CSS and LTCH sector, the LHIN will engage directly to assist in meeting the SAA expectations.

Key Issues:

- New QIP requirement to have CCAC and Long-Term Care Home to submit QIPs to HQO by April 1, 2014.
    - Fostering change management strategies to successfully implement LHIN-wide Quality Plan.

Successes of Past Year:

- Quality Engagement:
    - The LHIN has engaged its HSPs and partners, on advancing system-wide QI. Over the past year, LHIN staff have presented at various sector and network meetings and sessions introducing the HNHB LHIN's quality agenda. A call was made out to HSPs in all sectors for participation in the QGC. Members were selected on past experience in successfully implementing QI strategies in their organizations and/or throughout the health system. The QGC has met three times in 2013, and has discussed how provincial priorities will align with HNHB LHIN's Quality Plan. Specifically, the QGC wants to ensure alignment with HQO's Common Quality Agenda (CQA). As such, the group has determined a short list of indicators from the CQA to select a common indicator for implementation LHIN-wide. Overall, the LHIN will continue to ensure that QI focusses on advancing the patient experience.

The HNHB LHIN engaged its citizen reference panel to discuss their views and possible role in providing citizen and patient advice to inform quality planning. This will be carried forward with engagement through this group:

- The LHIN worked with sector partners to develop tools to build capacity across the key building blocks of quality improvement, including:
- Governance best practices
    - Utilizing data to drive improvement through a balanced scorecard.
    - Selecting and implementing best practice to improve quality.

PART 2: GOALS and ACTION PLANS

Goal(s):

- QGC will continue to advise the LHIN on the spread of quality in the LHIN.
- HSPs will receive feedback from the LHIN on the quality plans in an effort to continually improve.
- There will be an investment in the leadership within the LHIN (both LHIN staff and HSP's) in an effort to drive change management and capacity planning.

Consistency with Government Priorities:

Delivering quality of care is a foundational core principle to every health care provider. This is supported by the legislative requirements set out in the ECFAA. This is also consistent with the Ontario Action Plan for Health Care. LHIN's have worked in conjunction with the Ministry to integrate elements of quality improvement into SAAs.

Recently negotiated SAAs include quality obligations to enhance both system-wide and organizational level improvement activities. The LHIN's quality obligations are in alignment with initiatives through HQO and the Health Quality Branch (HQB) of the Ministry.

Action Plans/Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column					
	2014-15		**2015-16**		**2016-17**	
Examples:	Status	%	Status	%	Status	%
LHIN-wide quality plan will be in place by April 1, 2014.	Complete	100				
LHIN-wide quality plan will spread improvement methodologies across providers			Complete	100		
LHIN-wide quality plan will sustain progress across providers.					Complete	100
LHINs will evaluate quality plans and provide meaningful feedback to build HSP capacity and showcase best practices.	Complete	100				
The LHIN will work with HSPs to identify key change agents to facilitate the spread and sustainability of its quality plan.	Complete	100				
The LHIN will work with HSPs to build capacity of change agents.	In progress	50	In progress	50		
The LHIN will work to integrate internal staff capacity building into this sustainability plan.	In progress	50	In progress	50		

How will we measure success?

- There will be one quality indicator identified that all HSPs will monitor.
- An evaluation process will be developed for the LHIN to review and evaluate the HSPs quality plans.

- Establish a 'council of mentors' to provide guidance to the LHIN on leadership investment strategies to advance system-wide QI. This will include recommendations on focused leadership training for HSP leaders.
- Develop opportunities for LHIN staff to augment their leadership skills.

What are the risks/barriers to successful implementation?

- Administrative burden.
- Resistance to standardization.
- Resistance to change.
- Information technology (IT) challenges.
- Understanding of the tools, techniques and methods for QI.
- Physician engagement.

For each risk/barrier, describe the plan to mitigate the risk?

- The HNHB LHIN will continue to work directly with providers, the Ministry and HQO to leverage common tools and templates, to assist HSPs in focusing on their quality work rather than research best practice methodologies.
- Through the QGC and peer groups, the HNHB LHIN will facilitate a dialogue on the imperative for standardization for enhancing both the patient experience and value.
- The HNHB LHIN will utilize change management to facilitate provider buy-in, and translate strategy into execution.
- The HNHB LHIN will ensure physician engagement at all stages of developing the QI strategy.

What are some of the key enablers that would allow us to achieve our goal?

- Change management methods and techniques.
- Effective technology and information systems.
- Staff and physician engagement.
- Patient engagement.
- Sharing of data, best practices, and experiences.
- Effective physician engagement committees and depth of staff experience.

Additional Comments (i.e. additional information that supports the implementation/success of the goal).

3.2. Dramatically improving the patient experience by integrating service delivery

i. Health Links

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Dramatically improve the patient experience by integrating service delivery: Health Links

IHSP Priority Description:

Integrated service delivery means the system will be redesigned to ensure the person is at the centre of care. This will include:

- Health Links - appropriate services are 'wrapped around' the person through the creation of Health Links. Closest to the person will be their primary care provider who will be supported by a diverse and capable network of community services, including CSS, M H and A local hospital services and LTC.
- Health Links represent a new model of care delivery, where all providers in a geographic area are charged with coordinating plans at the patient/client level.

Initiatives planned and implemented within these strategies will include and collaborate with the LHIN's Aboriginal and Francophone population.

Current Status:

Health Links were announced by the Minister in December 2012, with the Hamilton Central Health Link announced as an 'early adopter'. Health Links will be accountable to LHINs to put collaborative initiatives in place, that will allow for a measurable, positive impact on the care of individuals in the Health Link geography. Health Links will focus initially on the 'high user' population cohort in their geographic area. This cohort is defined as individuals who have had at least three unplanned, acute care admissions and at least five unscheduled Emergency Department (ED) visits within the last year. While the number of individuals in this cohort varies across Health Links (from under 100 to over 300), their characteristics are remarkably similar – median age in the mid-60's, with multiple chronic conditions (including Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and diabetes, among the most common diagnoses) and underlying MH and A issues.

Each Health Link will be able to look at the specific individuals in their area, and develop coordinated plans that will improve their outcomes and reduce unnecessary use of the system.

Key issues:

- Health Links must include:
  - A minimum population of 50,000.
  - A minimum of 65% of primary care providers in the area.
  - A critical mass of providers who are willing to sign a partnership agreement.

Successes of the Past Year:

- Since the announcement of Health Links in December 2012:
  - The HNHB LHIN's early adopter – the Hamilton Central Health Link – was successfully established, with the Business Plan complete and approved.
  - Readiness assessments have been submitted for the remaining ten Health Links, with nine being approved by the Ministry.
  - Niagara North West Health Link submitted their business plan.

- Business planning is well underway in the remaining Health Links, with a particular focus on regional coordination of new and supportive initiatives.
- A unique and innovative primary care leadership model has been established to ensure that the perspective of family physicians is appropriately incorporated into the evolving model.

PART 2: GOALS and ACTION PLANS

Goal(s):

For 2014-15:

- All 11 Health Links will have their readiness assessments approved by the Ministry.
- All 11 Health Links will have developed and submitted a LHIN-reviewed business plan to the Ministry.
- Care planning will be occurring across all Health Links for those patients deemed to be "high users".

A framework will be developed that will assist with planning for:

- Migrant workers.
- Refugees.
- Homelessness.

Develop a vision for Health Links 2.0:

- Develop goals and outcomes.
- Look at the population beyond the top 5%.
- Begin to explore how Health Links may evolve from a reactive to a proactive/intervening stance.
- Develop a plan on how Health Links could provide advice to the LHIN on the needs of the population and the services required.

Consistency with Government Priorities:

- HLs were announced by the Minister in December 2012. The LHIN's SHSP anticipated HLs and, as a result, our strategic directions are in alignment with the Ministry.
- HLs represent a new model of care delivery, where all providers in a geographic area are charged with coordinating plans at the patient/client level.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2014-15		**2015-16**		**2016-17**	
	Status	%	Status	%	Status	%
• Secure the approval of the ministry in the establishment of 11 Health Links within the HNHB LHIN.	Complete	100				

• Support the Hamilton Central Health Link in the implementation of their approved Business Plan.	Complete	100				
• Provide direction, support and leadership to the remaining Health Links to ensure the submission of their business plans by the end of Q1 (2014/-15).	Complete	100				
• Provide leadership, coordination and support in implementing the approved business plans of the Health Links, with a particular focus on regionalization, realizing efficiencies and leveraging existing assets.	In Progress	30	In Progress	30	In Progress	30
• Collaborate with local and provincial partners in the implementation of a comprehensive connectivity solution.	In Progress	30	In Progress	30	In Progress	30
• Ensure that care plans are being developed for high use patients across the LHIN.	In Progress	40	In Progress	30	In Progress	30
• Collaborate with local and provincial partners in articulating a vision and work plan for the next evolution of Health Links (i.e. "Health Links 2.0").	In Progress	75	In Progress	25		
• Collaborate with the Ministry, the Health Links, and local resources on the development of a performance management system through which to track progress against business plan and care planning goals.	Complete	100				
• Develop a social determinants of health framework to assist with planning.	Complete	100				

How will we measure success?

The Ministry has identified 11 indicators which all Health Links will measure:

1. Ensure the development of coordinated care plans for all complex patients.
2. Increase the number of complex patients and seniors with regular and timely access to a primary care provider.
3. Reduce the time from primary care referral to specialist consultation.
4. Reduce the number of 30 day readmissions to hospital.
5. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere.
6. Reduce time from referral to home care visits.
7. Reduce unnecessary admissions to hospitals.
8. Ensure primary care follow-up within seven days of discharge from an acute care setting.
9. Enhance the health system experience for patients with the greatest health care needs.
10. Achieve an ALC rate of nine per cent or less.

11. Reduce the average cost of delivering health services to patients without compromising the quality of care.

Initially, Health Links will focus on the following in relation to the "high user":

1. Develop and implement coordinated care plans for complex patients.
2. Increase the number of complex and senior patients with regular timely access to a primary care provider.
3. Undertake patient and family engagement initiatives.

What are the risks/barriers to successful implementation?

- Multi-sectoral participants (primary and specialty care, hospitals, CCAC, community partners) are challenged in understanding (and consequently embracing) the vision of the initiative.
- Existing demands upon time and resources (related to fiscal pressures or case/patient volumes) translate into concerns regarding the participants' ability/willingness to become involved with the necessary collaboration and coordination aspects.
- The reluctance of a mandated partner may impact the ability of the Health Link to develop (regardless if majority acceptance is in place).
- The medical component of the Health Link is not accountable to the LHINs (thus potentially affecting the ability of the LHIN to support the development and implementation of the Health Link).
- The willingness/ability of physicians to support Health Links may be impacted should involvement not be considered revenue neutral.
- Participants doubt their ability to successfully support the Health Links vision given that both patients and services cross different Health Links geographic areas.
- The absence of a common and unified technology framework supporting necessary connectivity is perceived as a threat to a major tenet of Health Links (coordination).
- Lack of clear, consistent and universally-accepted e-Health work plan.
- Lack of clarity with regards to accountability among the Health Links – especially those that are directly funded by the Ministry as it pertains to the MLPA and the LHIN.

For each risk/barrier, describe the plan to mitigate the risk?

- Every opportunity of engagement with participants is utilized as a way to explore the challenges, barriers and gaps that they experience with regards to supporting patient care. Care is taken in highlighting how the vision of Health Links has evolved as a direct response to many of these challenges. The value proposition is established in showcasing how Health Links has the potential to tangibly address these identified challenges.
- Health Links represents not just a dramatic reaffirmation of a commitment to patient care, but also a significant opportunity to redefine how participants collaborate and communicate with one another. Emerging technology enablers (i.e. the increasing scope/prevalence of Ontario Telemedicine Network (OTN)) as well as an interest in non-conventional interaction (e.g., 'huddles') are showcased as indicative of how Health Links will actually evolve to reduce the demand historically associated with the logistics behind collaboration and coordination.
- The LHIN continues to develop compelling value propositions and embrace early champions in an effort to highlight the relevance and importance of Health Links.

The LHIN is visiting communities large and small in an effort to understand and address any doubts, concerns or uncertainty regarding how Health Links may positively impact patient care

- Respecting existing accountability mechanisms with other organizations, the LHIN is focusing on the very unique challenges and uncertainties that may surface from the medical component of the model. An emerging appreciation

of greater system involvement and partner participation is encouraging moving forward.

The LHIN identifies and partners with physician champions whenever possible in engaging the wider provider community.

- In meeting with primary care providers across many communities large and small, the LHIN is demonstrating its understanding and appreciation of the physician's commitment to practice and care obligations. As such, the LHIN is visiting providers where they work and where they live, and at hours more conducive to their scheduling preferences. In addition to redefining how collaboration and coordination actually occurs, Health Links will work to bring together partners in a way that is convenient, relevant and valuable.
- The LHIN has emphasized that providers' ability to refer patients across Health Links will not be affected. Also, the LHIN has acknowledged that supporting patients across different areas and providers is certainly a challenge. The LHIN continues to highlight the importance of connectivity and the various enablers associated with such communication emerging through the Health Links initiative.
- Health Links will offer participants to become engaged in developing solutions to the ongoing challenge of technology as it relates to connectivity across the continuum of care.
- Local experts and Ministry resources alike will be called upon to explore the specific issues and challenges put forth and, consequently, work in capitalizing upon local and emerging assets in developing a solution.
- The focus is on early traction with regards to addressing such challenges. It is understood, however, that the road towards comprehensive system connectivity is a longer-term objective.
- Continue to communicate the need for clarity, consistency and direction to the Ministry with regards to the project management component of Health Links.

What are some of the key enablers that would allow us to achieve our goal?

- Clear and consistent messaging regarding what Health Links offer with regards to supporting patients and families across the continuum of care.
- Positioning the LHIN as the accountable organization and as an enabler and facilitator of the work of partners and providers who are intimately aware of the successes, challenges, opportunities and barriers within their unique geographic areas.
- Engaging champions across various sectors in supporting the Health Links initiative.
- Emphasizing the focus of action over planning; that real change – driven from locally-driven solutions – is not just a possibility, but it is inevitability.
- Supporting the development of a clear, encompassing and universally-accepted project management plan across all aspects of the Health Links work. This includes – but is not limited to – the connectivity/eHealth component, performance metrics/processes, and a standard definition of a "Health Links" patient.

Additional Comments (i.e. additional information that supports the implementation/success of the goal).

- Focus remains on building a system that is sustainable and responsive over time (as opposed to crafting together short-term solutions for a distinct cohort).
- Supporting both patients and their families through providing services at a local level, with the objective of improving population health and patient/family satisfaction.
- Educate and build awareness of such services, to empower patients/families to make informed health care choices.
- Pursuing a system that is simplified, relevant and powerfully coordinated, in the interest of the patient.

ii. LHIN-wide Integrated Clinical Programs

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: LHIN-wide Integrated Clinical Programs.
IHSP Priority Description:
Integrated service delivery means the system will be redesigned to ensure the person is at the centre of care. This will include: • LHIN-wide integrated clinical programs providing specialized services to LHIN residents. LHIN-wide integrated clinical programs will coordinate and standardize clinical service delivery across the LHIN, including: o Common definitions and patient flow processes. o Common care model and quality improvement approaches, based on leading practices. o Projected need and distribution of services (population based). o Common outcomes, goals, and deliverables. o Increase standardization and the reduction of clinical variation across LHIN providers. o The key concept behind LHIN-wide integrated clinical programs is 'one clinical program – multiple sites', ensuring that all residents across the LHIN have access to a coordinated program, following the same care delivery and quality standards. Initiatives planned and implemented within these strategies will include and collaborate with the LHIN's Aboriginal and Francophone population.
Current Status:
Currently, most hospital-based clinical programs are delivered on an organization basis, with varying degrees of linkage between hospitals and across the continuum of care. The HNHB LHIN SHSP identified variation in health outcomes across our LHIN, with inequitable access to health services and variation in the application of best practice guidelines. Hospitals have, in many cases, become the default health system treating people with preventable health conditions, and for whom other supports and self-care could have prevented serious illness. Integrating and coordinating a standardized approach to service delivery in selected clinical program areas is a key goal for this IHSP priority. **Key issues:** • High rates of ED visits for conditions that could be managed elsewhere, and high rates of hospitalization for ambulatory care-sensitive conditions. • Variation in access to the full continuum of care, including specialized health services and variation in the use of best practice guidelines. • Current hospital utilization rate in the HNHB LHIN is high compared to the province, and projected utilization is not sustainable. **Successes of the past year:** Following the LHINs Clinical Services Plan (CSP) in 2009, work proceeded on the development of a number of LHIN-wide programs. The following highlights some of the recent successes:

- Oncology: the HNHB LHIN Integrated Cancer Services Plan (ICSP) has organized cancer services in the LHIN by developing a standardized approach across the LHIN for disease-specific treatments and patient care plans. Key accomplishments of the ICSP include:
    - Development and signed Partnership Commitment Agreements.
    - Established Cancer Councils at Joseph Brant Hospital (JBH), Brantford Community Health System (BCH), Niagara Health System (NHS) and St. Joseph's Healthcare Hamilton (SJHH).
    - Opened new Walker Family Cancer Centre, which included a new state of the art chemo suite, the recruitment of a Medical Oncologist, and one Full-Time Equivalent (FTE) Hematologist.
    - Established an Integrated Radiation Treatment Program.
    - Establishment of Regional ColonCancerCheck Networks of nine hospitals with a focus on improving quality and performance of endoscopy procedures.
    - Establishment of Ontario Breast Screening Program (OBSP) High Risk Screening Diagnostic Imaging (DI) Group to review quarterly performance and process issues for high risk Magnetic Resonance Imaging (MRI).
    - Creation of ColonCancerCheck (CCC) education toolkit for physicians and nurses educating in a primary care setting to improve uptake of appropriate screening modality for colon cancer.
    - Launched Mobile Cancer Screening Coach
    - Established Regional HNHB Thoracic Program
    - Established Lung Diagnostic Assessment Program (DAP) at SJHH, Niagara Health System (NHS) and Brantford Community Healthcare System (BCHS)
    - Implemented Integrated Comprehensive Care (ICC) Lung Cancer Project (reduced length of stay, ED visits, and readmissions and increased patient satisfaction)
    - Cancer Care Ontario (CCO) primary care lead has become an active member on the HNHB LHIN Primary Care Network (PCN)
- Laboratory services: In June 2012, the HNHB LHIN hospitals established a LHIN Laboratory Council, implementing central leadership for the administration of laboratory services offered at each participating hospital laboratory site. Six of ten hospital corporations are participating, representing approximately 90% of the total annual LHIN hospital laboratory test volume of 12.7 million tests. Centralized administrative leadership has enabled the implementation of the integrated program framework, resulting in a QIP with targets including improved turn-around times for troponins, reduced variation and improved quality, and enhanced performance monitoring. A Memorandum of Understanding (MOU) is currently in progress of completion to extend and expand the existing commitment beyond June 2014. Completed integration of the Regional Microbiology Network through consolidation and oversight from Regional Microbiology Committee with microbiology services for Joseph Brant Hospital (JBH) now purchased through the HRLMP. Full implementation of Microbiology Automation Technology at the Hamilton General Hospital site of HHSC is anticipated in 2014 with the Walk Away Specimen Processing (WASP) system coming online to improve standardization.

  The Lab Medical Directors have established LHIN-wide critical value test results and standardized reporting for many common tests.
- Vascular services: To support implementation of an Integrated Vascular Service, a MOU is being signed across all HNHB LHIN hospitals. To enable care provision close to home outpatient vascular clinics have been established across the HNHB LHIN with LHIN-wide credentialing of vascular surgeons. The two dedicated regional vascular inpatient beds and a LHIN-wide no refusal policy have ensured patients receive timely quality care. As well, the number of Endovascular Aneurysm Repair (EVAR) procedures being performed is meeting the expected target.

- The Integrated Vascular Clinical Services Plan is currently completing year three of the implementation plan with sustainability planning in process and identified deliverables for years four and five. The Provincial Vascular Planning Group is developing a provincial vascular plan, and is using the HNHB LHIN Integrated Vascular Clinical Services Plan as a model to be included in this provincial plan. In addition, the LHIN-wide Life and Limb no refusal policy has been successfully implemented across the HNHB LHIN.
- Thoracic services: All HNHB LHIN hospitals have implemented standardized definitions of non-malignant thoracic surgery and an urgent care algorithm as a major component of the Thoracic Clinical Services Plan. To enable care provision close to home and ensure no refusal for patients requiring tertiary level care, a repatriation agreement has also been signed by all HNHB LHIN hospitals. SJHH, as the lead for the Thoracic Clinical Services Plan, has developed a website for both patients and health care professionals, which provides information specific to thoracic surgery. The Thoracic Clinical Services Plan has been fully implemented and SJHH is currently monitoring this plan to ensure its sustainability.
- Diagnostic Imaging: All HNHB LHIN hospitals have been engaged in planning to target improved efficiencies with a focus on metrics identified in the Access to Care PIP 3 dashboard and the MLPA target. HSPs were actively engaged in determining a blitz funding framework to address long wait priority four cases for MRI. Efficiencies targeting block booking, rapid assessment protocols, best practice sharing (within and across LHINs), data quality checks, and education strategies, have been key to enhancing standardization in service delivery for DI services this year. The identification of HSP leadership for administrative and physician leads is currently in process and ongoing to assist with strategic planning and goal execution.
- Mental Health and Addictions: SJHH has been identified as the LHIN-wide lead to work towards a LHIN-wide program for adult inpatient MH and A services. With the completion of the new West 5th campus of SJHH (February 2014) and the new St. Catharines site of the NHS (March 2013), the LHIN will have significantly expanded inpatient schedule 1 and tertiary psychiatry capacity. Other schedule 1 capacity exists at BCHS and JBH. A MH Advisory group was established in 2013, with SJHH identified as the LHIN-wide lead organization. The Advisory Group has identified four areas of focus for 2014-15:
    - Enhance medical collaboration.
    - Enhance system performance.
    - Target priority populations.
    - Enhance collaboration and integration.
- Orthopaedics and Total Hip and Total Knee Replacements: The Integrated Orthopaedic Capacity Plan (IOCP) is complete, and LHIN-wide improvement strategies are being developed and implemented as a result. These strategies consist of LHIN-wide standardized pre and post-operative physician order sets, patient care pathways and patient educational material.
- Cardiac: Catheterization and Percutaneous Coronary Intervention (PCI) services: On April 16, 2013, the Integrated Heart Investigation Unit (IHIU) at NHS St. Catharines site opened to provide diagnostic cardiac catheterization services to residents of Niagara. The IHIU at NHS is an integrated partnership between Hamilton Health Sciences Corporation (HHSC) and NHS. As of November 30, 2013, the program had performed 739 cardiac catheterizations at the NHS site, and is projecting to complete 1,212 cardiac catheterizations by March 31, 2013.

  The Integrated IHIU program operates as a one program – multiple site model. Successes include:
    - Centralized referral and triage at HHSC.
    - Standardized policies, procedures, protocols, patient education, staff education and documentation across the program.
    - One Medical Director and Clinical Manager for the two sites (NHS and HHSC).

- Mentorship/secondment agreement between the two hospitals in place.
- Interventional cardiologists work at both sites.
- IHIU Quality Committee established.
- Emergent Transfer Plan (ETP) for transfers between NHS and HHSC finalized.
- Service agreement between NHS and HHSC for shared care model, Governance and Management, Supply Chain Management, Health Safety and Labour Relations signed April 2013.
- HNHB LHIN managed the transfer of funding quarterly between HHSC and NHS.
- Program development to implement PCI services April 2014.

PART 2: GOALS and ACTION PLANS

Goal(s):

- A template for the development of hospital-based LHIN-wide programs will be completed to:
  - Develop the principles.
  - Develop the policy.
  - Develop a process guide/toolkit.
- The following hospital-based LHIN-wide programs will continue to be implemented:
  - Ophthalmology.
  - Orthopedics.
  - Cancer.
  - Laboratory Medicine.
  - Diagnostic Imaging.
  - Cardiac PCI.
- The following hospital-based LHIN-wide programs will be started:
  - Gastroenterology (GI).
  - MH and A (hospital and community).
- The following hospital-based LHIN-wide programs will have a baseline evaluation as it relates to access to care and timeliness of treatment:
  - Vascular.
  - Thoracic.
  - Stroke.
  - Complex Care.

LHIN-wide performance indicators related to the programs (2 and 3) will meet the expected targets as identified in the MLPA.

Consistency with Government Priorities:

LHIN-wide integrated clinical programs will:

- Promote equitable access to health and health care for all residents

- Improve quality by reducing variation and standardizing care delivery models
- Improve transitions through common patient flow processes
- Support right care, right time, right place.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2014-15		**2015-16**		**2016-17**	
	Status	%	Status	%	Status	%
Complete Template for development of hospital-based LHIN-wide programs	Complete	100				
Oncology: **Strengthen the Integrated Regional Cancer Program:** • Develop and implement a regional Decision Support Network. • Develop and implement site specific scorecards for the region's hospital-based Cancer Quality Councils. • Identify and action three opportunities for clinical collaboration across the HNHB LHIN. • Evaluate the transition of care model for breast cancer, and the potential for a colorectal model. • Develop a new Integrated Oncology Program organizational structure for the integrated cancer program between the Walker Family Cancer (WFCC) Centre and the Juravinski Cancer Centre (JCC) guided by the external consultant's report. **Improve the Patient Experience:** • Engage patients to participate in Cancer Councils, committees and/or networks, as appropriate. • Increase the use of electronic pain & symptom management tools (i.e. Edmonton System Assessment System (ESAS), Palliative Performance System (PPS) across the LHIN to ensure access to appropriate services. • Evaluate patient attitudes to Non-Same Day Chemotherapy Administration Model. • Implement "How did we do Today" evaluation cards at the Juravinski Cancer Centre (JCC) and evaluate the benefit of this approach.	In Progress	50	In Progress	25	In Progress	25

Strengthen Cancer Prevention, Screening and Diagnostic Assessment Programs: • Develop and implement a smoking cessation pilot at JCC. • Develop the operational plan for the Canadian Imperial Bank of Commerce (CIBC) Breast Assessment Centre. • Expand the Lung Diagnostic Assessment Program (L-DAP) and Nurse Navigator Model to Brantford. • Evaluate potential for regional colorectal, prostate, esophageal DAPs. • Lead a 3rd Regional CCC Workshop to increase capacity for colonoscopy across the LHIN. • Evaluate the effectiveness of the CCC Education Tool Kit in Primary Care Practice settings. • Develop and implement a plan to increase Aboriginal Cancer Screening across all three screening modalities. • Oversee strategies to achieve LHIN-wide wait time targets for cancer surgery (ongoing).						
Laboratory Services: • Integrated Lab Information System. • Coordinate LHIN-wide specimen transportation. • Consolidate specialized testing, where possible, within existing space. • Continue to plan for a centralized Lab facility (following Ministry capital submission and review process). • Add remaining hospitals to Integrated Laboratory Services Program. • Standardize critical value test results and reporting. • Develop a Genetics/Molecular Diagnostics working group to identify service and access needs, complete a regional needs assessment and gap analysis, and subsequently complete an implementation and strategy execution plan. • Implementation of QIP performance measures across the LHIN.	In Progress	50	In Progress	25	In Progress	25

• Full implementation of microbiology automation technology with reduction in sites performing bacteriology. • Development of QI plan for 2014. • Implementation of standardized testing for transfusion medicine and consolidation to two sites, with required testing on site at all hospital laboratories.						
Gastroenterology (GI): • Establish leadership groups and initiate an integrated program planning process.	In Progress	25	In Progress	50	In Progress	25
Mental Health and Addictions: • Establish an integrated MH and A Advisory group; develop current state assessment; complete framework for integrated program and service delivery. • Establish MH and A physician group to identify and implement select standardized best practice initiatives. • Develop a standardized MH scorecard across hospital and community providers. • Develop and implement LHIN-wide concurrent disorders and early intervention progress. • Explore opportunities for MH and A system integration at the zone level. • Establish a residential community withdrawal management program in Brant County with LHIN-wide integrated and standardized program elements. • Oversee strategies to achieve LHIN-wide targets for repeat ED visits for MH and A.	In Progress	25	In Progress	50	In Progress	25
Orthopaedics (Total Joint Replacement (TJR)): • Implement LHIN-wide standardized pre and post-operative physician order sets, patient care pathways, and patient education material. • Establish HNHB LHIN Orthopaedic Leadership Committee with clear deliverables. • Implement recommendations from the Leadership Committee. • Oversee strategies to achieve LHIN-wide wait time targets for hip and knee replacement.	In Progress	60	In Progress	40		

Cardiac (PCI services): • Implement PCI services at NHS - St Catharines Site through Integrated Model with HHSC.	Complete	100				
Diagnostic Imaging: • Interventional Radiology: establish an integrated program working group; develop current state assessment; complete framework for the integrated program and service delivery. • Establish lead organizations and team members to participate in a LHIN-wide DI program. • Implement standardized rapid assessment protocols for MRI across the LHIN. • Implement a LHIN-wide QIP for MRI and Computed Technology (CT). • Review the opportunity for inter-LHIN coordination and strategic planning. • Complete a review of opportunities for improvements for pediatric MRI and CT access for (pay for results) p4 cases. • Review the opportunity for centralized access to DI. • Oversee strategies to achieve LHIN-wide wait time targets for MRI and CT.	In Progress	50	In Progress	25	In Progress	25
Ophthalmology – (cataracts): • Establish an HNHB LHIN Ophthalmology Leadership Committee with clear deliverables. • Develop an HNHB LHIN Ophthalmology CSP. • Implement recommendations from the Leadership Committee. • Oversee strategies to achieve LHIN-wide wait time targets for cataract surgery	In Progress	60	In Progress	20	In Progress	20
Vascular Services: • Establish outpatient clinics, to be located at HNHB LHIN hospitals. • Complete sign-off on MOU between hospitals. • Identify future services alignment opportunities and shift towards increasing minimally invasive procedures. • Establish and implement standardized, evidence based vascular care protocols.	In Progress	75	In Progress	25		

• Undertake baseline evaluation of access to care and timelines.						
Thoracic Services: • Monitor each of the metrics established for the Thoracic clinical services plan. • Monitor patient satisfaction for the Lung Diagnostic Assessment Program (LDAP), Esophageal Diagnostic Assessment Program (EDAP) and thoracic surgery programs. • Implement improvement strategies as a result of low performing metrics. • Implement improvement strategies as identified by patient satisfaction results. • Undertake baseline evaluation of access to care and timelines.	In Progress	75	In Progress	25		

How will we measure success?

- Adoption of common assessment, referral, placement/admission and discharge criteria for LHIN-wide integrated programs, starting with those identified above.
- Implementation of best practice clinical standards and guidelines across the LHIN.
- Identified clear roles, responsibilities and accountabilities adopted.
- Implementation and ongoing monitoring of evaluation and performance monitoring metrics, including the following MLPA indicators:
    - Increase percentage of surgeries completed by priority wait time targets (cancer, cardiac bypass, cataract, hip and knee).
    - Increase percentage of diagnostic scans (MRI and CT) completed by priority wait times targets.
    - Reduce repeat unplanned ED visits within 30 days for MH and A.
- Identification of program size, scope and distribution for clinical services, with defined implementation plan.
- Elimination of duplicated low volume, high complexity services.
- Improved access with care provided closer to home.
- All hospital Laboratory services part of integrated program.
- PCI services are provided at the NHS (St. Catharines) through the integrated model – one program, two sites.

What are the risks/barriers to successful implementation?

- IT – success depends upon the availability of shared patient information; significant investment in eHealth is required to facilitate integration.
- Practice and cultural barriers – different styles of practice, culture and administration may lead to conflict.
- Human Resources (HR) labour agreements may impact timing of implementation where resources need to move.
- Inadequate resources may be allocated to change management strategies, to build coherent new teams and units.
- In-year priorities from the Ministry may delay or defer goals/activities as outlined.

For each risk/barrier, describe the plan to mitigate the risk?
• Ensuring integrated plans are cost neutral. • Follow local eHealth plan and capitalize on external opportunities. • Build principles, processes and sustainability into transition plans. • Engage physician and HR leadership in processes. • Goals/activities will be prioritized if new in-year priorities are added.
What are some of the key enablers that would allow us to achieve our goal?
• Physician engagement. • Consistent integration tools, templates and processes utilized throughout each planning and integration process will ensure success of our goals.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

iii. LHIN-wide Population Based Strategies

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: LHIN-wide Population-Based Strategies
• IHSP Priority Description:

• LHIN-wide population-based strategies refers to initiatives (service delivery models/programs) that support the health care needs and/or optimize the health status (wellness) of 'specific populations', by providing a coordinated and integrated approach to service delivery. This will include:
  ○ Equitable access to population based strategies.
  ○ Standardized models of care that are based on evidence best practice or expert recommendations that will decrease variability improve client outcomes and create system efficiencies.
  ○ Opportunities to provide care in the community setting are optimized (right care in the right place).
  ○ Provide a resource for primary care, hospitals and other HSPs.
  ○ Complement or coordinate with other initiatives.
  ○ Demonstrate common outcomes.
  ○ Provide effective and seamless care transitions.
• Specific populations include:
  ○ Older Adults, their families and caregivers:
  • Interventions to prevent or reduce functional and/or cognitive decline.
  • Expansion of wellness programs within congregate community settings.

- Improve caregiver's access to programs that provide respite care.
- Improve effective, timely and seamless transitions.

- Individuals who require timely access to hospital ED services.
- Individuals with complex or chronic conditions with a focus on stroke care, diabetes, COPD, CHF, Acquired brain Injury (ABI) and developmental disabilities.
- Individuals who require hospice palliative care.
- Initiatives planned and implemented within these strategies will include and collaborate with the LHIN's Aboriginal and Francophone population.

Current Status:

LHIN-wide population based strategies

Priorities:

Older Adults - Their Families and Caregivers:

- Supporting individuals' transition to the right level of care has been a key priority in the LHIN's Patient Flow Strategy.
- From August 2012 to April 2013, HNHB LHIN hospitals maintained an ALC rate (open cases) ranging from 12.1% to 12.9 %, with the exception of January 2013 when the rate increased to 13.7%[10]
- In April 2013, the LHIN saw an incline in the number of individuals waiting for an Alternate Level of Care (ALC) across LHIN hospitals (409 in April 2013, to 535 in November 2013). This increase, coupled with individuals experiencing long waits for certain destinations (patient's choice LTCH, assisted living/group homes) impacted the Acute ALC rate negatively (up to 16.9% in November 2013). A factor contributing to the LHIN's patient flow pressures was the increase seen in the number of patients admitted to hospital through the ED, especially in Hamilton (please refer to ED section).
- HNHB LHIN HSPs continue to work collaboratively to facilitate patient's timely transition to most appropriate level of care with a focus on the older 'high risk' population.
- Home First: - The HNHB CCAC took more patients home supported with high levels of care (>8 hours per day) to support and address hospitals' patient flow pressures. In the first five months of 2013-14, CCAC took 434 individuals home with levels of care that were more than eight hours per day (65% increase over the same period in 2012-13)[11]. Of the 434 patients discharged home, 239 received levels of care greater than 16 hours per day. Of these, 175 (73%) were discharged from HHSC, SJHH and JBH.
- In 2013-14 the HNHB LHIN provided the HNHB CCAC with over $22 million in new funding (base and one-time).
- Assess and Restore Approach - Restorative Care: To support individuals who need access to restorative programs to regain their optimal functional status following an acute illness, the LHIN continued to support 124 restorative beds in seven locations across the LHIN. As of September 2013, 488 individuals were discharged from these programs, of whom, 78% were discharged home[12]. In addition, the LHIN expanded convalescent care capacity within the LHIN by 28 beds, increasing the LHIN's Convalescent Care program to 63 beds.

[10] HNHB LHIN Hospital Trigger Reports 2012-13

[11] HNHB CCAC Service Maximum Data Provided October 2013

[12] Hospital second quarter performance reports, October 2013

- Rapid Response Transitional Care Team (RRTT): The RRTT is a comprehensive strategy to support complex adult and paediatric populations transitioning home to reduce hospital readmissions. The RRTT focuses on preventing avoidable ED visits and/or hospital admissions, as well as facilitating discharge home for clients at risk of becoming ALC or those already identified as ALC. The RRTT team incorporates 14 rapid response nurses, six transitional care nurses and four nurse practitioners. The team has access to both professional and PSWs and access to pharmacists that will provide in-home visits for medication reconciliation, post-discharge, for individuals who cannot go to their community pharmacy.
- Exercise and Falls Prevention Classes: The HNHB LHIN, through its Aging at Home (AAH) initiative, funded a Falls Prevention strategy that included exercise classes targeted to the high risk senior population. In 2013-14, the HNHB LHIN, as part of the changes to Ontario's publically-funded physiotherapy service, funded over 150 sites (exercise or falls prevention). The majority of these classes replaced existing classes and targeted the senior population. The timeline to implement the new programs did not allow the opportunity to standardize processes and admission criteria.
- Behavioural Supports Ontario (BSO): The BSO strategy focuses on improving care through supporting transitions, system navigation, and coordinating services for older adults (and their caregivers) who exhibit, or are at risk of exhibiting, responsive behaviours. The LHIN has engaged in ongoing efforts to integrate and sustain the BSO service models (summarized below) into practice throughout 2013-14. These service models support the continuum of care, reaching the community, LTC, and key transitions from hospital. Collaborations among agencies, ongoing stakeholder engagement, and a continuous QI approach to identify system gaps and explore opportunities for system re-design, are some of the practices that foster improvements in care. The BSO Service Model includes:
    - BSO Connect – One point of entry for clients, caregivers and providers to access assistance; provides a warm connection the most appropriate agency; pulling services toward clients.
    - BSO Community Outreach Team (COT) – Five teams with geriatric expertise provide "just in time" (crisis) support to clients linking them to longer-term support; built within crisis mental health teams.
    - Integrated Community lead (ICL) – Where one agency is the single point of contact (for BSO clients and other providers servicing the client), and navigates the client through the health system; functions built into existing roles.
    - BSO LTC Mobile Team - Implemented across the LHIN, serving the LHIN's 86 LTCHs.
- Caregivers – Access to Respite (Adult Day Care and Respite Programs): Adult day services and respite programs provide therapeutic activities, exercise, education and caregiver support. The target population includes seniors and caregivers living in the community. HNHB LHIN HSPs have identified increasing pressures to meeting the needs of their population that are requiring levels of care that exceeds their resources. A review of LHIN- funded programs will be completed in 2014.

Access to ED Services:

- The HNHB LHIN has 12 hospital EDs across the eight hospital corporations. Eight ED sites participate in the Ministry's Pay for Results (P4R) initiative. The ED at the HHSC-McMaster site is a dedicated ED for children and youth. In the first six months of 2013-14, LHIN EDs reported 269,330 visits; this is 27,477 more reported visits during the same period in 2012-13 (241,853). This increase is a continuation of the trend seen in 2012-13[13].

[13] Source: ER Public Reporting and Pay for Results Hospital Comparison Report. Access to Care, Cancer Care Ontario.

- The LHIN has been challenged to improve the ED length of stay (LOS) for the admitted patient population. A review of ED data comparing April 1, 2013 to June, 30 2013, to the same period in 2012 for this population revealed[14].
    - An increasing trend in the number of patients admitted through the ED (18,027 vs. 17,157) Individuals admitted through the ED are triaged using a five level Canadian Triage and Acuity Scale (CTAS) with one being the most acute. Growth was demonstrated in the higher acuity population; CTAS 1-3 of 9.6%, 7.9% and 4.3% respectively, while CTAS 4 and 5 have decreased by 13.9-19.5%.
    - The LHIN geography showing the highest increase in ED admissions was the Hamilton area (72%).
    - The age group demonstrating the greatest growth was the population aged 64 years and older.
    - A 14% increase in admissions through the ED for the population 75 years and older on CCAC services at time of registration.
- As of September 30, 2013, the LHIN's 90th percentile LOS for the three broad ED groupings were:[15]
    - Admitted patients – 35.5 hours (33.4 hours at the end of Q2 in 2012-13).
    - Non-admitted High Acuity Patients – 7.4 hours (7.8 hours at the end of Q2 in 2012-13, and lower than the LHIN's 2013-14 MLPA target).
    - Non-admitted Low Acuity Patients – 4.4 hours (4.8 hours at the end of Q2 in 2012-13, and lower than the LHIN's MLPA target).

3. Complex and/or Chronic Conditions:

3.1. Diabetes:

- As of March 31, 2011, the HNHB LHIN had 121,559 persons living with Diabetes. This is 10.44% of the HNHB LHIN population and is the third highest compared to all other LHINs[16].
- In 2013, the Ministry transitioned the accountability of nine Adult Diabetes Education Programs (DEPs), four Paediatric DEPs, and one Regional Coordinating Centre to the HNHB LHIN. The Adult DEP programs are located at the following sites: Bridges CHC, North Hamilton CHC, Le Centre de Santé communautaire Hamilton-Wentworth-Niagara Inc. CHC, BCHS, HHSC, NHS, SJHH, and Norfolk General Hospital (NGH). The Paediatric DEPs are located at the following sites: HHSC, NHS, BCHS, and JBH.
- The Family Health Team (FHT) DEPs were transitioned to the Primary Healthcare Branch at the Ministry, and the remaining DEPs were transitioned to the Implementation Branch of the Ministry. FHT DEPs within the HNHB LHIN are located at Caroline FHT, Garden City FHT, Niagara Medical Group FHT. DEPs transitioned to the Implementation Branch in the HNHB LHIN include: De dwa da dehs nye>s Aboriginal Health Centre, Six Nations Health Services and Southern Ontario Aboriginal Diabetes Initiative.

3.2. Stroke:

- The release of the 2012 Ontario Stroke Report Card identified that for the second year in a row, the HNHB LHIN fell below the benchmark on all 20 stroke indicators, which served as a catalyst for change. The HNHB LHIN, in consultation with the Central South Regional Stroke Network (CSRSN), identified opportunities to improve stroke care and outcomes in both the short and long-term. The LHIN, in collaboration with the CSRSN Coordinator, the

[14] Source: NACRS, HNHB LHIN IDS. Accessed November 2013. (Of note comparison of volumes reported by ATC-CCO in the Public Reporting and P4R Report 2013-03 and the 2013-08 report shows an increase in the admitted population of 1,070).

[15] Source: ER Public Reporting and Pay for Results Hospital Comparison Report. Access to Care, Cancer Care Ontario.

[16] Source: Institute for Clinical Evaluation Sciences: Regional Measures for Diabetes Burden in Ontario April 2012.

Regional Medical Director for Stroke, and hospital leaders integrated stroke services within Brant, and Haldimand-Norfolk, at BCHS in June 2013.
The LHIN, the CSRSN, hospital leaders and the HNHB CCAC worked together to develop a Community Stroke Rehabilitation Model (CSRM). The pilot for the CSRM launched in Brant and Haldimand-Norfolk in December 2013.

3.3. COPD and CHF:

- The rate of HNHB LHIN hospital readmissions within 30 days is significantly influenced by patients with CHF and COPD. In 2013-14:
- The LHIN approved $2M base funding to develop a COPD Community Integrated Management Program across the LHIN. Initially the programs will target the population at risk of readmission to hospital.
- LHIN hospitals implemented a Discharge Transitions Bundle which streamlines transition from hospital to community for patients with most responsible admitting diagnosis of COPD and CHF.

3.4. Developmental Disabilities (DD) and ABI:

- Access to appropriate levels of care has been identified as a barrier to discharge for a small number of individuals waiting in hospital. As of September 16, 2013, 15 individuals were waiting in hospital for supportive living, nine diagnosed with DD and two with ABI. Days waiting in hospital ranged from one month to four years[17].
- The LHIN's Patient Flow Steering Committee (previously referred to as ALC Steering Committee), established a working group to develop strategies to reduce wait times for individuals waiting in hospitals for supervised assisted living environment/group homes for these populations.

Hospice Palliative Care –End of Life (EOL) Care:

- Provided in community, hospitals and long term care. The LHIN supports five residential hospices through funding provided to the CCAC for a total of 42 beds. As of October 2013, 437 individuals[18] received care at these five hospices. The LHIN also supports Good Shepherd's Emmanuel House, a ten bed program that provides hospice services.

4.1. Palliative Care Community Services:

- Includes the Palliative Pain and Symptom Management Consultants Program, the Interdisciplinary Community-Based and Physicians Education Programs, and the Palliative Care Volunteer Visiting Program.
- Other palliative care assets in HNHB include:
    - Formalized Interdisciplinary expert Palliative Care Shared Care Outreach Teams.
    - Prevalence of Alternate Forms of Physician Payments (APP), which better supports a community model of care (compared to fee for service).
    - Links to McMaster – Department of Family Medicine and Division of Palliative Care.
    - Two Cancer Centres.
    - Long-standing tertiary care consult teams.
    - Designated hospital-based complex care – EOL beds.
    - Hospice Palliative Care Network (Pre- 2004 Ministry End of Life Strategy (EOLS)).

[17] HNHB LHIN Survey LHIN Hospitals September 2013.

[18] HNHB CCAC January 17, 2014

Key Issues:

The HNHB LHIN has demonstrated an increasing trend in the number of patients admitted through the ED. In 2012-The HNHB LHIN EDs reported 2,758 additional admissions over 2011-12. This trend continues to be seen in 2013-14. In Q1 of 2013-14 HNHB LHIN hospitals admitted 870 more patients compared to Q1 2012-13 (18,027 vs. 17,157).

- In the first quarter of 2013-14, the HNHB LHIN reported the third highest ED admission rate per 1,000 population for the population 75 years and older of all Ontario LHINs (57.5 per 1000 population)[19].
- Individuals waiting in hospital for LTC who have limited choices or have chosen LTC homes with long waits (measured in years).
- Limited access to group homes/supportive housing for patients waiting in hospital with challenging behaviours.
- A number of LHIN hospitals that have limited number of private rooms, are challenged by the number of individuals admitted through the ED requiring isolation precautions.
- Lack of standardized approaches in providing hospice palliative care services, and lack of communication and collaboration between providers (siloed).
- Hospice palliative care - poorly understood by the larger medical community and the general public.
- Supporting continuation of exercise and falls prevention classes in locations that do not provide optimal space or access prevented optimal use of resources (existing programs located in locations that could not accommodate 35 individuals).
- BSO - High turn-over of LTCH staff, impacting capacity building related to management of individuals with challenging responsive behaviours.
- Challenges with cross-agency / sector collaborations that hinder smooth care transitions for BSO target population.

Successes of past year:

- As of November 2013, despite patient flow pressures and an increasing trend in the number of patients admitted through the ED, the LHIN has maintained the number of patients waiting in hospital for LTC across HNHB LHIN hospitals to less than 200, compared to 360 reported in August 2010.[20]
- Demonstrated a decrease of 2,640 ALC days (33%) for the population aged 75-84 and 620 ALC days (8%) for the population 85 years of age during April 1 2013 – June 30 2013, compared to the same period in 2012.[21]
- Early Intervention Screening in LHIN EDs. As of November 2013, 2,461 individuals were identified as high risk and referred to CCAC. 1,052 individuals were currently known to CCAC and connected with their care coordinator, 1,409 were not known to CCAC and were connected with a care coordinator. Of these, 454 were admitted to CCAC and received services[22].28 additional convalescent care beds opened in 2013-14 (20 in Niagara and an additional eight in Hamilton) providing access for hospital patients from across the LHIN.
- The Rapid Response Transitional Team (R2T2) program served 1,731 patients, of these 1,206 were admitted from hospital.[23]
- Integrated complex care program implemented across LHIN hospitals.

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[19] IntelliHealth Ontario, Ontario Ministry of Health and Long-Term Care. Inpatient Discharges Main Table and Population Projections 2013 by LHIN Table.

[20] HNHB CCAC.

[21] Source: WTIS ALC Accessed Nov 2013

[22] HNHB CCAC EIS Report November 2013.

[23] HNHB CCAC HNHB CCAC Rapid Response Transitions Teams – Second quarter report 2013-14).

- ED Critical Link (a HNHB LHIN project where smaller hospital ED are connected through a MOU with a larger hospital ED for timely consultations and transfers of patients who need care beyond what is available at the smaller hospital) implemented across all LHIN EDs. As of December 2013, there were 39 referrals, through this program resulting in 28 transfers. In 93% of the transfers, transport time was less than four hours; 100% of the transfers occurred in less than six hours.[24]
- As of September 30, 2013, the LHIN met the MLPA indicator for non-admitted ED population.
- ED Coaching Team Pilot program developed and implemented. Coaching Team visited JBH January 30 & 31, 2014. Coaching Team's final report pending.
- Implemented standardized best practice treatment protocol for migraines developed based on research conducted at McMaster University across LHIN EDs.
- Community Referrals by Emergency Medical Services (EMS) (CREMS) implemented by EMS serving HNHB LHIN. In 2013, Hamilton EMS referred 226 individuals to CCAC through the CREMS program.[25]
- As of June 2013, acute and rehabilitative stroke care services were integrated within Brant Haldimand and Norfolk at BCHS to improve access to best practice integrated stroke unit care.
- A CRSM was developed and launched in Brant, Haldimand and Norfolk December 2013.
- Expanded the HNHB LHIN Leaders in Diabetes group to include representatives of all DEP programs (Ministry and LHIN-funded).
- Developed standardized DEP quality metrics that will be reported and reviewed quarterly.
- Identified DEPs that are potentially underutilized and/or duplication of services.
- Implementation of LHIN-wide Discharge Transition Bundle across for COPD across LHIN hospitals.
- Development and planning of COPD Integrated Management Program, which will be available in each of the LHIN's three zones and will begin implementation by March 31, 2014.
- Exercise and Falls: Completed Request For Proposals (RFP); replaced 129 classes in existing retirement homes and congregate living settings that had previously received Ontario Health Insurance Program (OHIP) billed exercise and falls classes. Expansion of 39 new sites and five sites that have both replacement and expansion classes running.
- LTCHs: All 86 LTCHs have either an interim plan or have gone out to a RFP to secure physiotherapy services for their residents.
- CCAC In-Home – CCAC now the sole provider of all in-home one on one physiotherapy services. CCAC connected with all HNHB retirement homes and transitioned 100% of residents requiring ongoing physiotherapy.
- Designated Physiotherapy Clinics – Completed review of RFPs received by the Ministry, and recommendations for locations and applicants submitted to the Ministry-based on population needs.
- Demonstrated a decreasing trend in ALC palliative days from 2011-12 baseline (10,386 days), (9,284 days), in 2012-13 and as of December 13, 2013 (- 7,371 days).[26]
- Implemented an advanced care planning and health care consent tool kit and e-learning module, which trained several champions across HSP organizations and was also incorporated into the Long-Term Care Service Accountability Agreement (L-SAA) as a performance indicator.

[24] Criticall January 17, 2014.
[25] Hamilton EMS January 15, 2014
[26] WTIS Pulled December 10, 2013

- Completed four Value Stream Mapping (VSM) to sessions inform the drafting of a HNHB Regional Palliative Care Program and undertook extensive consultation.
- Four BSO service models fully implemented: As of September 30, 2013, the following programs reported the following activity:
    - BSO Connect linked 329 clients to services.
    - BSO COT served 539 clients.
    - BSO Connect and BSO COT performed system navigation for 830 clients.
    - BSO LTC Mobile team served 889 clients and performed 13,725 client-based services.
- ICL service model is active with all 41 community agencies identified through the Multi-Sector Service Accountability Agreement (M-SAA), participated in regular regional Hub meetings throughout the 2013-14 year.
- QI initiatives have been ongoing throughout the implementation and sustainability of the BSO models, including: 39 tests of change Plan-Do-Study-Acts (PDSAs), and the development of 13 new tools in Q1 and Q2 2013-14.

PART 2: GOALS and ACTION PLANS

Goal(s)

2014-15 LHIN-wide population based strategies are in place and have the following goals.

Older Adults, their families and caregivers:

- Interventions to prevent or reduce functional and/or cognitive decline:
    - Assess the impact of the Seniors Mobile Assess Restore (AR) Teams piloted in February and March 2014, for impact and based on results, incorporate this program into the HNHB AR bedded model and identified as a Senior Friendly Hospital initiatives for other hospitals to adopt.
    - Facilitate an expert panel to analyze a small cohort of high risk BSO clients in LTC to identify alternate strategies to avoid unnecessary transfer to hospital.
    - Review LHIN-funded Exercise and Falls Prevention programs to increase standardization across programs.
- Expansion of wellness programs within congregate community settings
    - Identify opportunities to expand the AR and/or Transitional Care programs in the community.
    - Facilitate the development of a standardized process where eligible clients can be transitioned from CCAC to Community Support Assisted Living/Supportive Housing Providers.
- Improve caregivers access to programs that provide respite care
    - Complete a review of LHIN-funded adult day programs and respite programs to identify current status, populations served, barriers, issues, gaps, duplications by July 2014.
- Improve effective, timely and seamless transitions (patient flow metrics)
    - Reduce ALC days for select discharge destinations that will include long-term care and supervised or assisted living, which will decrease the LHIN's total ALC rate with a goal of meeting the LHIN's MLPA target of 12%.

Access to hospital ED services:

- Reduce the overall ED LOS for the admitted patient population to meet MLPA targets by
  - Identifying and addressing challenges at underperforming hospital sites
  - Reducing ED LOS from registration to decision to admit to meet the provincial average with a focus on two hospital corporations.
- Develop and implement treatment protocol for Acute Myocardial Infarction (AMI).
- Work with one hospital ED and key community agencies to explore ways to improve communication, discharge planning and care coordination for the BSO population.

Complex or chronic conditions with a focus on stroke care, diabetes, COPD, CHF, ABI and DD:

- Stroke:
  - Improve residents' access to integrate community stroke rehabilitation services in Haldimand, Norfolk and Brant.
  - Reengage with NHS to develop an integrated stroke unit.
- Diabetes:
  - Improve the utilization of all LHIN-funded DEPs. All LHIN-funded DEPs will report a minimum caseload benchmark > 50% of provincial target.
  - Improve access to DEPs through standardized referral processes.
  - Eliminate areas of duplication by shifting resources to areas of need.
- COPD and CH:F
  - Reduce LHIN-wide readmission rate for COPD at 30 days and one year following hospital discharge (baseline readmission rates for 2012-13: 30 day - 20%; one year – 49%)
  - Implement a community-based program for patients with COPD in each of the three LHIN zones of Hamilton/Burlington, Brantford/Haldimand/Norfolk, and Niagara.
  - Improve standardization of CHF management practices and processes across LHIN hospitalsΔ.
- ABI and DD:
  - Development of a process where individuals living with ABI or a DD who are admitted hospital can maintain their linkages with their community resources (where they exist) to facilitate seamless transition at dischargeΔ.
  - Develop a standardized process to establish a forum for review of individuals with ABI and DD who have barriers to hospital discharge.

Hospice Palliative Care:

- Support of the successful completion of the LHIN's commitment under the Declaration of Partnerships, including:
  - The HNHB LHIN will have in place a regional structure for palliative care, and that the regional structure will have been in place for at least 12 months.
  - An Expert Hospice Palliative Care Regional Program Council will be established to advise the LHIN on Palliative Care Services.

Complete a review of Hospice Palliative Care Services across the LHIN. The review will include the types of programs/services, utilizations, wait times, geographic access, outcomes, ALC data, emergency room/hospital utilization and cost analysis.

Δ ***Indicates a goal that may be deferred if another provincial priority project is identified (for which we currently do not have knowledge).***

Consistency with Government Priorities:

Each of these goals is consistent with:

- The Minister's Action Plan for Health Care, whose three foci include:
  1. Keeping Ontario healthy – through early detection and better management of chronic conditions, and ensuring care is patient centered, driven by outcomes and based on evidence.
  2. Faster access and a stronger link to family health care - by improving system navigation (especially for seniors), supporting patients at key transition points, ensuring they are linked with primary care.
  3. Right care, right time, right place – by providing the right care by the most appropriate care provider and in the right place and where 'home' is always considered first.
- LHIN's SHSP and Integrated Health.
- Ministry's Ontario Action Plan for Seniors (2013).
- BSO Provincial Strategy.
- Rehabilitative Care Alliance.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2014-15		**2015-16**		**2016-17**	
Examples:	Status	%	Status	%	Status	%
Older Adults, their families and caregivers • Assess the impact of the Seniors Mobile Assess Restore Teams piloted in February and March 2014, for impact and based on results incorporate this program into the HNHB AR bedded model, and identified as a Senior Friendly Hospital initiative for other hospitals to adopt.	In Progress	75	In Progress	25		
Older adults, their families and caregivers: • Facilitate an expert panel to analyze a small cohort of high risk BSO clients in LTC to identify alternate strategies to avoid unnecessary transfer to hospital.	Completed	100				
Older adults, their families and caregivers: • Review LHIN-funded Exercise and Falls Prevention programs to increase standardization across programs.	Completed	100				
Older adults, their families and caregivers: • Identify opportunities to expand the AR and/or Transitional Care Programs in the community.	In Progress	75	In Progress	25		

Older adults, their families and caregivers: • Facilitate the development of a standardized process where eligible clients can be transitioned from CCAC to Community Support Assisted Living/Supportive Housing Providers.	In Progress	75	In Progress	25		
Older adults, their families and caregivers: • Complete a review of LHIN-funded adult day programs and respite programs, to identify current status, populations served, barriers, issues, gaps, duplications by July 2014.	Completed	100				
Older adults, their families and caregivers: • Reduce ALC days for select discharge destinations, that will include LTC and supervised or assisted living, which will decrease the LHIN's total ALC rate with a goal of meeting the LHIN's MLPA target of 12%.	Completed	100				
Access to hospital ED services • Reduce the overall ED LOS for the admitted patient population to meet MLPA targets by: o Identifying and addressing challenges at underperforming hospital site o Reducing ED LOS from registration to decision to admit to meet the provincial average with a focus on two hospital corporations.	Completed	100				
Access to hospital ED services • Develop and implement treatment protocol for AMI.	In Progress	75	In Progress	25		
Access to hospital ED services • Work with one hospital ED and key community agencies to explore ways to improve communication, discharge planning, and care coordination for the BSO population.	In Progress	75	In Progress	25		
Chronic or Complex Conditions – Stroke: • Improve residents' access to integrate community stroke rehabilitation services in Haldimand, Norfolk and Brant.	In Progress	50	In Progress	50		
Chronic or Complex Conditions – Stroke: • Reengage with NHS to develop an integrated stroke unit.	In Progress	75	In Progress	25		

Chronic or Complex Conditions- Diabetes: • Improve the utilization of all LHIN-funded DEPs. All LHIN-funded DEPs will report a minimum caseload benchmark > 50% of provincial target.	Completed	100				
Chronic or Complex Conditions- Diabetes • Improve access to DEPs through standardized referral processes.	Completed	100				
Chronic or Complex Conditions – Diabetes • Eliminate areas of duplication by shifting resources to areas of need.	Completed	100				
Chronic or Complex Conditions – COPD • Implement a community-based program for patients with COPD in each of the three LHIN zones of Hamilton/Burlington, Brantford/Haldimand/Norfolk, and Niagara.	Completed	100				
Chronic or Complex Conditions -COPD and CHF • Improve standardization of CHF management practices and processes across LHIN hospitals.	In Progress	25	In Progress	75		
Chronic or Complex Conditions – ABI and DD • Development of a process where individuals living with ABI or a DD who are admitted hospital can maintain their linkages with their community resources (where they exist) to facilitate seamless transition at discharge.	In Progress	50	In Progress	50		
Hospice Palliative Care • The HNHB LHIN will have in place a regional structure for palliative care and that the regional structure will have been in place for at least 12 months.	Completed	100				
Hospice Palliative Care • An Expert Hospice Palliative Care Regional Program Council will be established to advise the LHIN on Palliative Care Services.	Completed	100				
Hospice Palliative Care • Complete a review of Hospice Palliative Care Services across the LHIN. The review will include the types of programs/services, utilizations, wait times, geographic access, outcomes, alternate level of care data, emergency room/hospital utilization and cost analysis.	In Progress	75	In Progress	25		

How will we measure success?

- Reduction in LHIN ALC rate to <12%.
- Reduce the ALC days associated with individuals waiting in hospital for restorative programs (AR, Slow Stream Rehab, Convalescent Care, Complex Care Restorative – base line for 2012-13 = 18,211 ALC days).
- Reduce the ALC days associated with individuals waiting in hospital for palliative care (2012-13: - 9,284)
- The number of individuals waiting in hospital for placement to LTC will be < 200.
- Standardized processes identified for LHIN-funded falls prevention and exercise classes.
- Increase in the number of congregate restorative settings that provide access to 24/7 support in the community (baseline 5).
- Completion of a report detailing LHIN adult day program and respite service capacity, population served, services provided, utilization, service gaps, LHIN resources and recommended actions (if applicable).
- LHIN ER LOS from presentation to decision to admit will be reduced, to be equal or lower than the provincial average.
- Standard AMI treatment protocol will be developed and implemented by all LHIN EDs.
- Reduction in LHIN ER LOS for admitted patient population to meet MLPA target (28 hours).
- Reduction in the LHIN readmission rate for stroke, COPD and CHF, impacting the LHIN's MLPA target for readmission for select Case Mix Groups (CMGs).
- LHIN-funded DEPs will report a minimum caseload benchmark > 50% of provincial target.
- LHIN will improve access to DEPs services through the reallocation/movement of resources.
- Stroke-Increased proportion of individuals post-Stroke/Transient Ischemic Attacks (TIAs) treated on a stroke unit at any time during their inpatient stay in Brant, Haldimand and Norfolk as noted on the site specific stroke report card.
- Three COPD Integrated Management Programs established across the LHIN.
- Meet targets for number of patients completing the COPD Integrated Management Program (Target 2014: 15, 850).
- HNHB Palliative Care Regional Program Structure will be approved by the HNHB LHIN Board.
- Report from the expert work group for high risk BSO clients in LTCH that includes recommendations for future consideration.
- Report on barriers and potential processes to improve communication and discharge planning for the BSO population in the ED for submission to the LHIN Emergency Services Steering Committee (ESSC).

What are the risks/barriers to successful implementation?

- Identification of new priority projects that required dedicated LHIN staff resources (i.e. Physiotherapy reform in 2013-14). LHIN Projects that may be deferred should this occur include: standardized heart failure processes practices across LHIN hospitals, facilitate process to transition those CCAC clients who could be served by CSS agencies, process to maintain linkage with community agencies for persons with ABI and DD when hospitalized.
- Develop a process for a standardized forum to review individuals.
- Capacity of community service providers to meet demand (CCAC, Community Support Services).
- Access to Primary Care to provide services on evenings and weekends.
- Hospital's capacity to introduce new processes/protocols within the proposed timeframe.
- Continue increasing trend in the number of individuals admitted to the hospital though the ED.

- Demand on ED services as a result of Influenza-like outbreaks.
- Number of individuals admitted through the ED that requires isolation protocols.
- Impact of infection control outbreaks on patient flow.
- Timing and impact on Ministry funding reform (QBP for stroke) on program integrations.
- Number of individuals who wait in hospital for their first choice LTCH.
- Availability of group homes/supporting living settings for individuals with DD and ABI.
- Availability of health human resources (HHR).

For each risk/barrier, describe the plan to mitigate the risk?

- Enhance the range and scope of congregate alternative settings available in the community.
- Optimize opportunities for ALC settings within the community.
- Enhance opportunities for CCAC and CSS agencies to work within a shared care model.
- CCAC and hospitals to work together to maintain a bed management system that supports system flow.
- Hospitals to increase linkages with community partners that can assist with navigation through system to enable timely discharges.
- HealthForceOntario and other recruitment strategies.
- Increased public education regarding flu prevention and treatment options.
- Work with the LHIN ED Physician Lead and LHIN hospitals with high admission rates, to identify the specific barriers and methodology for changing the admission rates, while still maintaining high clinical standards.
- COPD: Continuous monthly evaluation of the COPD Integrated Management Program for first year of implementation. Larger evaluation after six months of operation to assess opportunities to expand referral sources to include primary care, Health Links, and the ED, and offer outreach services to rural communities.

What are some of the key enablers that would allow us to achieve our goal?

- Continued financial support for community investments and P4R initiatives.
- Increased availability of health care options including Primary Care availability on evenings and weekends.
- Health links implemented and operational across the LHIN.
- Access to acute and timely data.
- Policies that advance and support wellness programs within congregate community settings.
- Committed partnerships between community service providers.
- Leadership support from the LHIN and that of the LTCH Network Council representative on the BSO Management Committee.
- Connectivity of electronic medical records (EMRs).

Additional Comments (i.e. additional information that supports the implementation/success of the goal).

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: LHIN-wide Population Based Strategies: Aboriginal Health
IHSP Priority Description:
Healthy Families, Healthy Children, Healthy Communities
Current Status:
According to a 2009 report prepared by the Ministry's Health Data Branch, in 2006, there are 24,456 people who are identified as Aboriginal in the HNHB LHIN (on and off Reserve Registered Counts). Of these, 11,947 were on reserve and 12,509 off reserve. According to data from Indian and Northern Affairs Canada, the age distribution of Aboriginal peoples who live on reserve is considerably younger. Seniors account for approximately 6.1% of the Aboriginal population who live on reserve in First Nations co-located in the HNHB LHIN. Seniors account for approximately 12.7% of aboriginal individuals living off reserve compared to 15.8% of seniors that reside in the LHIN as a whole. Overall, the aboriginal population has a younger age demographic as compared to the population of the HNHB LHIN. The LHIN currently provides funding to two Aboriginal HSPs as follows: • De dwa da dehs nye>s (The Aboriginal Health Access Centre). • Native Horizons Treatment Centre. The LHIN also provides funding to two First Nations as follows: • Six Nations of the Grand River Territory. • Mississaugas of the New Credit. There are a number of additional Aboriginal HSPs in our LHIN, while not funded by the LHIN, collaborate with the LHIN through the Aboriginal Health Network (AHN). These HSPs include three Friendship Centres, as well as several native housing and women organizations. In 2013-14, funding continued for the second year to the Native Horizons Treatment Centre for the Community Wellness Development Team. **Key Issues** • There are inherent challenges with utilizing census data to represent the aboriginal population due to under-coverage in the census of the aboriginal population living on reserve.[27] • The demographic profile of aboriginal people differs from non-First Nations populations with a younger age structure, higher fertility rates and greater mobility.[28] Canadian studies have consistently shown reduced life expectancy and poor health status for Aboriginal peoples compared to the general Canadian population and higher rates of chronic conditions.[29] ICES data reveals higher rates of chronic conditions, such as diabetes, among Aboriginal persons living on reserve in the HNHB LHIN.[30]

[27] MOHLTC Health Analytics Branch report "First Nations Peoples in Ontario: A Demographic Portrait" (January 2009)

[28] MOHLTC Health Analytics Branch report "First Nations Peoples in Ontario: A Demographic Portrait" (January 2009)

[29] Health Canada. A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003. Minister of Health: Ottawa, 2009. Available at: http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborigautoch/index-eng.php

[30] ICES. Chronic Conditions in Ontario. HNHB LHIN data from 2006-07.

- As described in a Hamilton Community report on First Nations Adults and Children in the City of Hamilton in 2011, First Nations people living in Hamilton are living with a disproportionate burden of disability and chronic disease. The key issues for Aboriginal health status when compared to other Hamilton residents are detailed below.[31] Broad applicability of the data outlining aboriginal health issues is limited due to the focus on Hamilton Residents.
    - Socioeconomics - The Aboriginal population has higher rates of transient housing, homelessness, and crowded housing. They have higher rates of spending more income on shelter-related costs giving up important things to meet those costs, and higher rates of not having enough food to eat. They have lower levels of education and dramatically lower incomes.
    - Health Status - The Aboriginal population has much lower self-reported health status. They also have three times the diabetes rate, twice the asthma rate, and higher rates of high blood pressure, arthritis, and hepatitis C.
    - Health Behaviours - The Aboriginal population has three times the rate of smoking and twice the rate of heavy drinking.
    - Health Utilization – over 50% of the Aboriginal population had visited the ED over a two year period. 10.6% report six or more visits to the ED over the same time frame.
- Lack of access to Aboriginal Traditional Healing was noted in the summary of recommendations for improving the aboriginal patient experience.[32]

Successes of past year:

In January 2012, the AHN identified three strategic priorities for their five year work plan, including: Youth mental health and the high rates of youth suicide; Chronic Disease management and the high rates of diabetes, and finally Strengthening the Family Unit and the high rates of family violence. In 2013-14, the AHN has accomplished the following activities to advance these priorities:

- Utilized the trainers trained last year in both Applied Suicide Intervention Skills Training (ASIST) Version 10 and Safe Talk Suicide Prevention to begin the roll-out of workshops to aboriginal HSPs and communities across HNHB. Initial projected targets for 2013-14 included 201 and 480 individuals trained respectively. As of March 2014, approximately 30% of the initial training targets were achieved therefore targets have been extended for completion 2014-15.
- 100% of the trainers also received additional training in this year to upgrade them to ASIST Version 11.
- As of March 2014, 13 targeted Aboriginal Cultural Sensitivity Training sessions were completed with one-time funding received from the LHIN. The AHN, along with lead agency De dwa da dehs nye>s Aboriginal Health Centre provided Cultural Sensitivity training sessions through the Ontario Federation of Indian Friendship Centres across the LHIN from August 2013 to March 2014, including LHIN Board and Staff, mainstream HSP CEOs, Executive Directors and Health Link Coordinators, EDs, Urgent Care Clinics and Emergency Medical Services, Primary Care and front line service providers to continue building cultural sensitivity towards the ongoing development of cultural competency and safety across the system.
- As of March 2014, the AHN joint HNHB Walk the Talk Health and Wellness Program achieved 88% participation by AHN organizational members to exemplify leadership in promoting Aboriginal Health to their service recipients across the HNHB LHIN area.

[31] Smylie, J. et al. "Our Health Counts. Community Report. First Nations Adults and Children City of Hamilton". (April 2011).

[32] Summary Recommendations for Improving the Aboriginal Patient Experience. Summary Report prepared for the Hamilton Niagara Haldimand Brant LHIN (March 2013).

- In September 2013, the AHN, along with lead agency De dwa da dehs nye>s Aboriginal Health Centre, received LHIN base funding for three FTE Aboriginal Patient Navigators for HNHB.
- On February 5, 2014, the AHN utilized Aboriginal Engagement Funds to continue ongoing consultations with both on and off aboriginal communities to explore strategies to include appropriate cultural practices to improve Aboriginal health outcomes.
- In 2013-14, LHIN one-time funding to Native Horizons Treatment Centre was utilized to train 10 trainers in Mental Health First Aid.

PART 2: GOALS and ACTION PLANS

Goal (s):

Mental Health Priority (HNHB AHN and Provincial Priority):

- Reduce the rate of Aboriginal suicide rates across the HNHB LHIN area by continuing to train the 201 Aboriginal individuals in ASIST, and 480 individuals in Safe TALK, and evaluate outcomes.
- Reduce the rate of Aboriginal persons developing a mental health problem or experiencing a mental health crisis across the HNHB LHIN area, utilizing the 10 Mental Health First Aid trainers to train 200 Aboriginal individuals, and evaluate outcomes.

Chronic Disease Priority (HNHB AHN Priority):

- Reduce the rate of Aboriginal chronic disease by continuing to implement the HNHB Aboriginal Walk the Talk Health Initiative, by supporting 15 Aboriginal organizations to implement activities to exemplify leadership in promoting health and wellness to their service recipients across the HNHB LHIN area. This will also include the continued development of a toolkit of resources and strategies to support the initiative and evaluate outcomes.

Cultural Sensitivity Training (HNHB AHN and Provincial Priority):

- Complete an evaluation as to the impact and effectiveness of Culture Awareness and Sensitivity Training completed to date, and determine the need for further training and target audiences.

Patient Navigation (HNHB AHN Priority):

- To assess the impact of improving the patients' experience, through access to Aboriginal Patient Navigators, and to identify the demand and utilization for Traditional Healing.

Consistency with Government Priorities:

The goals outlined are consistent with the Minister's Action Plan for Health Care, focused on the following:

- Keeping Ontario healthy
- Faster access and a stronger link to family health care
- Right care, right time, right place

Aboriginal populations is a priority population

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2014-15		**2015-16**		**2016-17**	
	Status	%	Status	%	Status	%
• Continue to train the 201 Aboriginal individuals in ASIST and 480 individuals in Safe TALK and evaluate outcomes.	Completed	100				
• Utilize the 10 Mental Health First Aid trainers to train 200 Aboriginal individuals and evaluate outcomes.	In Progress	50	In Progress	50		
• Reduce the rate of Aboriginal chronic disease by continuing to implement the HNHB Aboriginal Walk the Talk Health Initiative by supporting Aboriginal organizations to implement activities to exemplify leadership in promoting health and wellness to their service recipients across the HNHB LHIN area. • This will also include the continued development of a toolkit of resources and strategies to support the initiative and evaluate outcomes.	In Progress	30	In Progress	60	In Progress	10
• Complete an evaluation as to the impact and effectiveness of Culture Awareness and Sensitivity Training completed to date and determine the need for further training and target audiences.	Completed	100				
To assess the impact of improving the patients experience through access to Aboriginal Patient Navigators and to identify the demand and utilization for Traditional Healing.	In Progress	50	In Progress	50		
How will we measure success?						
• Increase in individuals trained in ASIST and Safe TALK. • Increase in individuals trained in Mental Health First Aid. • To improve the aboriginal patient's experience through the work of the aboriginal patient navigator and the walk the talk health and wellness program. • Increase aboriginal cultural awareness of health service providers throughout the LHIN.						
What are the risks/barriers to successful implementation?						
• Limited human resource and financial capacity of Aboriginal Organizations.						

For each risk/barrier, describe the plan to mitigate the risk?
• Work with the AHN to identify, prioritize and resolve organizational and systemic barriers.
What are some of the key enablers that would allow us to achieve our goal?
• Continued active engagement and dialogue with Aboriginal stakeholders to identify develop and implement solutions.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: LHIN-wide Population Based Strategies: Francophone Health
IHSP Priority Description:
The health of the Francophone population in our LHIN, including their access to health care services, continues to represent a priority for the LHIN.
Current Status:
The *FLSA Ontario, 1986,* guarantees the right of Ontarians to communicate with the government and receive services in French. According to the New Inclusive Definition of Francophone (IDF), there are over 35,000 Francophone in the HNHB LHIN. The IDF broadens the mother tongue indicator, and adds those persons who speak French, whose mother tongue is neither French nor English and for whom French is one of the languages spoken at home. This inclusive definition reflects better the evolution and diversity of the French-speaking Communities. The LHIN has two agencies designated under the *FLSA* and 30 agencies identified to provide over 40 programs/services in French. Access to services is challenged in the following ways: people are not comfortable asking for services in French; people do not know what services are available in French and where. In addition, French Language (FL) speaking health professionals are in short supply; there is variable commitment among stakeholders to meeting the needs of French speaking people. **Key issues:** • The Francophone population is dispersed across the LHIN, with concentrations in Hamilton and Welland/Port Colborne. • The population is not homogeneous (i.e. new Canadians from different francophone countries, French-Canadians from Ontario and other provinces where Francophones live in a minority situation) - health status, health needs and health-seeking behaviours are variable. **Successes this past year:** The *Entité de planification pour les services en français dans les régions de Waterloo, Wellington, Hamilton, Niagara,* the French Language Health Planning Entity (FLPE) for HNHB and Waterloo-Wellington (WW) LHINs is operational: • The Joint Liaison Committee (JLC), created with a mandate to develop appropriate mechanisms for collaboration and ongoing dialogue, meets at regular intervals throughout the year to discuss planning issues.

- Engaged and worked with the FLPE to meet objectives set out in the 2013-14 JAAP.

The LHINs and the FLPE continue to establish positive working relationships which will facilitate reaching our mutual goal of improving access to health services in French for our francophone communities. Presentations and on-going discussions with FLS-identified agencies increased knowledge and awareness of the FLSA, the LHINs role and mandate and the obligations of HSPs. This has resulted in:

- An increasing level of engagement of staff and departments as seen by responses in reports and increased request for information on French Language Services (FLS).

PART 2: GOALS and ACTION PLANS

Goal(s):

French Speaking Population:

- Increase knowledge and capacity of HSPs with respect to FLS.
- Continue to work with FLPE to identify strategies to improve access to FLS for people who speak French.
- Develop and implement a strategy to increase access to LTCH beds for French speaking individuals in Hamilton.
- Work with the FLPE to build on the existing toolkit of 'active offer' resources available to HNHB LHIN HSPs.

Consistency with Government Priorities:

- Access:
  - Ensure that Francophone population can access health services in French within reasonable reach.
- Accessibility:
  - Ensure the 'active offer' of health programs in French as well as availability of French-speaking HHR.
- Community Engagement:
  - Support the active participation of Francophones in public consultations and citizen/community engagement activities.
- Integration/Coordination:
  - Address the needs of Francophones, and ensure that programs and HSPs incorporate the principles of the FLSA and Local Health Systems Integration Act, 2006 (LHSIA), in their business processes to address the needs/concerns of Francophone clients.
- Evidence-Based Policy/Program Development:
  - Use the best information available about the needs of Francophones, demographic trends and the enhancement of Francophone-specific research to inform policy and program development.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2014-15		**2015-16**		**2016-17**	
Examples:	Status	%	Status	%	Status	%
• Increase knowledge and capacity of HSPs regarding FLS: o Promote use of existing FLS resources. o Specific capacity-building projects. o Build 'active offer'. o Monitor HSP progress/performance with respect to FLS implementation.	In Progress	25	In Progress	25	In Progress	25
• Continue to work with the FLPE to identify strategies to improve access to French Language Health Services (FLHS) for people who speak French: o Coordinate "joint liaison" efforts with FLPE to ensure appropriate completion of 2014-15 JAAP. o Review and coordinate response to FLPE required annual submissions.	Complete	100				
• Collaborate with, and coordinate LHIN involvement in, joint projects: o Access to LTCH beds in Hamilton	In Progress	50	In Progress	25	In Progress	25

How will we measure success?

- Progress report on implementation plan:
  - Number of FL-identified agencies who put a mechanism in place to identify Francophone client.
  - Number of FL-identified agencies who have FL speaking staff/health professionals.
- A strategy is implemented to improve access to LTCH beds in Hamilton for French speaking individuals.

What are the risks/barriers to successful implementation?

- Lack of FL health professionals able to provide services in French.
- Variable commitment among stakeholders to meeting the needs of FL speaking people.

For each risk/barrier, describe the plan to mitigate the risk?

- Assess capacity of providers.
- Increase awareness and knowledge of providers with issues.

• Continued work with FLPE. • Work with various stakeholders and partners.
What are some of the key enablers that would allow us to achieve our goal?
• The FLPE is operational and can assist the LHIN in engaging community, identifying gaps, bringing solutions through participation at LHIN planning tables. • Training of French-speaking health care professionals. • Access to translation services. • Work closely with the CCAC. • More information provided to the Francophone community
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

iv. Integrated Support Service System

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Integrated Support Service System
IHSP Priority Description:

• Integrated support services system - services that support care delivery will be coordinated to best reduce duplication within the hospital and community sectors. This may include:
  ○ Operational support (i.e. purchasing, finance, HR functions).
  ○ Integrated information management and decision support will build on LHIN-wide approaches to eHealth, OTN, common assessment (i.e., Resident Assessment Instrument-Community Health Assessment (RAI-CHA)), and the related Integrated Assessment Record (IAR).
  ○ Clinical support (e.g. Lab, DI).
  ○ Information management and decision support.

Current Status:
The HNHB LHIN holds 9 H-SAAs, 86 L-SAAs, and 96 M-SAAs with providers. While there are varying arrangements across parts of the system for shared support services, these arrangements are not comprehensive and, in the community sector, are largely ad hoc. Mohawk Shared Services Corporation currently provides many hospital-based shared support services, and is exploring further opportunities. Many localized arrangements for shared services exist in the community sector. **Key Issues:** • In a resource constrained environment, all HSPs need to be able to focus their attention and resources on patient/client care.

- Taking a comprehensive look at integrating support services may be one way to enable that focus, providing cost-effective solutions that allow for improved consistency in decision making and quality improvement.

Successes of the past year:

- Mohawk Hospital Services is currently developing a plan for shared accounts receivable/accounts payable functions across all hospital corporations.
- As an organization owned and operated by the LHIN hospitals, Mohawk is also exploring how other hospital support services might be shared through their structure.

PART 2: GOALS and ACTION PLANS

Goal(s):

A plan has been developed to identify how best to reduce duplication in administrative support services in the hospital and community sectors.

Consistency with Government Priorities:

Consistent with Ministry focus on value for money.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2014-15		**2015-16**		**2016-17**	
Examples:	Status	%	Status	%	Status	%
Work with Mohawk Shared Services to develop an integrated support services plan for the hospital sector, including: • Assessment of current status and additional need/opportunity. • Identification of service delivery model, based on leading practice review. • Development of business case and implementation plan.	In Progress	50	In Progress	25	In Progress	25
Work with CCAC and other community-based HSPs to develop an integrated support services plan for the community sector, including: • Assessment of current status and additional need/opportunity. • Identification of service delivery model based on leading practice review. • Development of business case and implementation plan.	In Progress	25	In Progress	25	In Progress	25

How will we measure success?
Reduced duplication of support services.
What are the risks/barriers to successful implementation?
• IT: success depends upon the availability of shared patient information; significant investment in eHealth is required to facilitate integration. • Practice and cultural barriers: different styles of practice, culture and administration may lead to conflict. • HR labour agreements may impact timing of implementation where resources need to move. • Inadequate resources may be allocated to change management strategies to build coherent new teams and units.
For each risk/barrier, describe the plan to mitigate the risk?
• Ensuring integrated plans are cost neutral. • Follow local eHealth plan and capitalize on external opportunities. • Build principles, processes and sustainability into transition plans. • Engage physician and HR leadership in processes.
What are some of the key enablers that would allow us to achieve our goal?
• Consistent integration tools, templates and processes utilized throughout each planning and integration process will ensure success of our goals. • Objective assessment of opportunities and service delivery models.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Electronic Healthcare (eHealth)
IHSP Priority Description:
Linked information for effective care and health system decision-making.
Current Status:
The HNHB LHIN eHealth Strategic Plan and direction outlines the leveraging of eHealth solutions to improve the way patients receive care. The principles to guide business planning and grow eHealth include: • Build on existing and scalable solutions. • Seize opportunities and align with current or planned initiatives and resources. • Choose solutions that promote ease of integrations and operation with other systems.

- Equip stakeholders with a minimum level of computerization to enable their participation.
- Share implementation costs between all providers who stand to benefit and improve patient care.

Successes of the past year:

- ClinicalConnect (common clinical information viewer which integrates data from 28 hospitals across HNHB LHIN and Waterloo-Wellington (WW) LHIN plus, two CCACs and the JCC.
- Over 6,000 physicians and providers are now enrolled in ClinicalConnect (an increase of 2,000 since previous year).
- eHealth funded project ($3.6M for HNHB LHIN and $1.6M allocated to WW LHIN) continued to support further adoption, mature governance, enhance supporting infrastructure and service management.
- eHealth Ontario providing additional funding for expansion of ClinicalConnect to two additional LHINs (LHIN 1 and 2) and for Change Management and Adoption.
- The $1M Canada Health Infoway funded project to roll-out ClinicalConnect Mobile, and to evaluate patient care and workflow improvement is nearing completion (over 650 provider's now using Mobile – an increase of 250 over previous year).
- Planning for extension of ClinicalConnect to LHIN (1 and 2) as part of South Western Ontario cluster (SWO) integration scheduled for 2014-15). The CCAC's in LHIN 1 and 2 will be integrated to ClinicalConnect in early 2014. Additional CCAC data will be also available.
- Improved inter-operation with hospital systems and community emergency medical records with single sign on and contextual launch to ClinicalConnect now live at HHS, NHS, JBH, and Brantford. Other hospitals and physician emergency medical records in HNHB LHIN and WW LHIN are being planned.
- Integration of the Ontario Laboratory Information System (OLIS) private / public laboratory data is in conformance testing. Delays due to resources and OLIS specification changes pushing the live date into 2014.
- Grand River Pharmacy Data was added and went live.
- Health Outcomes for Better Information and Care (HOBIC) Nursing Assessments is nearing completion and expected to go live January 2014.
- Diagnostic Imaging repository (DI-r) integration work is progressing with live targeted in 2014.
- Began planning to support Health Links (enhance connectivity and enable improvements). ClinicalConnect will display the frequent visitor / cohort. Work is in progress. Live date expected early 2014.
- Planning for e-Referral pilot project (Acute to CCAC), leveraging CCAC Client Health and Related Information System (CHRIS) system and ClinicalConnect.
- Planning for the support of the new provincial Hospital Report Manager standard to complete by end of 2013.
- Integrated Decision Support (IDS) Data Repository and Business Intelligence Solution – fully operational, expanding data sets. Implementing in Toronto Central (TC) LHIN, Planning South West (SW) LHIN.
- ALC wait time information system (WTIS) upgrade planned and pending funding.

Key issues for eHealth implementation:

- Evolving changes (timelines, resources, and provincial specifications).
- Local challenges recruiting resources, meeting escalating demands.
- Process or policies are not always in alignment, or support the new landscape.
- In some cases relative to Mobile usage, devices are not provisioned or not allowed or dated.
- Wi-Fi or data plan availability.

- Change in practice.
- Funding is largely project based, and does not address ongoing sustainability, although the cSWO program is to address in next Transfer Payment Agreement.
- Significant administrative overhead to manage reporting.
- Procurement policies extend timelines.
- HSP financial constraints to balance budgets impacting availability of funds to support local eHealth.
- Impact or changes with provincial health care policies and priorities, budgets.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Improve access to health information across the health care continuum.
- Improve patient care delivery through improved, timely access to information.
- Improve the ability of health professionals to access information to make informed decisions.
- Improve quality of care and reduce errors.
- Improve health system management.

Consistency with Government Priorities:

- eHealth will allow / secure exchange of patient information between healthcare organizations and clinicians.
- eHealth is a critical success factor for health system transformation, and is a government priority.
- eHealth Ontario is playing the lead role in harnessing IT and innovation to improve patient care, safety and access in support of the government's health strategy.
- Alignment with the eHealth Ontario directions and standards including Ontario Telemedicine Nursing Initiative.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2014-15		**2015-16**		**2016-17**	
	Status	%	Status	%	Status	%
• Expansion of ClinicalConnect adoption to more physicians, providers, HSPs in HNHB LHIN including education and change/transformational management / includes Mobile roll-out.	In Progress	50	In Progress	25	In Progress	25
• Continue to roll-out and improve interoperability (single sign on and patient contextual launch from Hospital and community EMRs).	In Progress	30	In Progress	60	In Progress	10

• Enhance Services and Support.	In Progress	50	In Progress	50	In Progress	
• Health Links Support – display frequent cohort in ClinicalConnect. Support advanced functionality and other integration (e.g.: Care Plans).	In Progress	50	In Progress	25	In Progress	25
• E-notification – leverage ClinicalConnect to support electronic notifications of patients from Acute to CCAC and Community Physicians.	In Progress	25	In Progress	50	In Progress	25
• Integration and leveraging of Provincial assets (One-ID, Client and Providers registries) – Pilot proof of concept to begin.	In Progress	50	In Progress	50		
• Expansion of ClinicalConnect to SW and Erie St. Clair (ESC) LHINS (LHIN 1 and 2).	In Progress	75	In Progress	25		
• Integration of SW and ESC CCAC data and the additions of CCAC data into ClinicalConnect.	Complete	100				
• Integration of DI-r into ClinicalConnect.	Complete	100				
• Expand downloading of reports to physician emergency medical records and provide support for Hospital Report Manager (HRM) (implementation and transition from existing). (Projected addition of OLIS data with HRM).	In Progress	50	In Progress	25	In Progress	25
• Leverage ClinicalConnect integration to feed OLIS Hospital lab data vs. multiple separate Hospital connections to OLIS.	In Progress	25	In Progress	50	In Progress	25
• Secure messaging introduction.	In Progress	25	In Progress	50	In Progress	25
• e-Referral directions approach and pilot.	In Progress	25	In Progress	50	In Progress	25
• Extend and enhance IDS expand data sets to include additional healthcare sectors.	In Progress	55	In Progress	25	In Progress	20
• Extend DI-r and increase adoption.	In Progress	25	In Progress	25	In Progress	25
• Resource Matching and Referral (RM&R) (Phase I) - HNHB LHIN is one of four LHINs in the cSWO Cluster participating in Referral Transformation: o HNHB eHealth, HHSC, CCAC pilot electronic referral project to inform RM&R.	In Progress	80	In Progress	20		

Describe how you measure success:

- Reduced repeat diagnostic tests.
- Improved work flow.
- Improved communication among health care providers.
- Improved patient safety and reduced medical errors.
- Improved quality of care.

What are the risks/barriers to successful implementation?

- Timeliness of decisions and /or delays in processes
- Timing of provider access to integrated decision support tool data and reports.
- Expansion of eHealth projects may outpace the availability of resources.
- Recruitment challenges (non-competitive salaries, location).
- Completing patient care priorities in a time of financial and economic constraint.

Mitigating Strategies:

- Availability of:
  - Implementation plan to ensure key provider data availability.
  - Implementation plan geared to resource availability.
  - Further partnering (e.g.: Mohawk College, McMaster University, secondments from partners).
  - Continue to adjust and evolve and mature eHealth program / establish new roles or revise existing roles and responsibilities / update compensation to attract and retain staffing.
  - Negotiate for more appropriate funding from eHealth and MOH (part of cSWO initiative).

What are some of the key enablers that would allow us to achieve our goal?

- Early announcement of planning allocations for hospitals will facilitate their budgeting.
- Availability of funding to hire resources to build eHealth capacity.
- Build expectation of participation into H-SAAs.

3.3. Dramatically improving the patient experience by evolving the role of the LHIN to become health system commissioners

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by evolving the role of the LHIN to become health system commissioners
IHSP Priority Description:
To evolve its role within their current legislative mandate, the HNHB LHIN will: • Become health system commissioners focusing on quality, volume, price, and accountability. • Commissioning is a complex process with responsibilities ranging from assessing population needs and prioritizing health outcomes to procuring products and services and funding bundles of services. As health system commissioners, the HNHB LHIN staff and Board will make health system decisions based on evidence and performance. • Building capacity in the health care system to advance quality improvement, requires continuous engagement and capacity building with HSPs on performance improvement to ensure that outcomes are being met for patients.
Current Status:
Citizens expect value from public services – including efficiency, effectiveness, affordability and quality. Compared with other Organization of Economic Cooperation and Development countries (OECD), the Canadian health care system has not consistently delivered high quality services at the most reasonable price point. The global economic slowdown has placed greater pressure on government funded services requiring ever more focused efforts at achieving a high value for health services. A key strategic priority for the HNHB LHIN is to ensure accessible, patient-centred services that also reflect value for money. The HNHB LHIN maintains 192 SAAs with providers, and is responsible for monitoring fiscal and operational performance. The HNHB LHIN also has a responsibility to work with individual providers on key system wide priorities, including ED wait lists, ALC, and a shift of services from the acute to community services. To drive a greater focus on value for money, the HNHB LHIN is adopting the best-practices from the commissioning of health services (a proven international best practice in health care management). A strategic focus on the tenants of commissioning will result in: • A focus on population health and gaps in service and not on providers. • A focus on common solutions that cross silos and traditional working relationships. • Making health system decisions based on evidence and performance. • Ensuring that the patient's needs are at the centre of decision making. Along the path toward adopting a commissioning strategy, the HNHB LHIN will continue and enhance its relationship with HSPs. The LHIN will work in partnership with HSPs to meet their legal obligations. This will include a performance management framework that will seek to answer the following key questions: • Are HSPs delivering what they're supposed to be delivering? (Effectiveness) • Are HSPs delivering services as efficiently as possible? (Efficiency) • Are there some things that other HSPs can do better? (Quality)

This work will support and advance the imperatives of implementing the government's HSFR, which is focused on funding providers based on their efficiency and patient activity rather than base budget increases.

The number and complexity of HSPs in our LHIN requires a prioritization based on the risk of not meeting performance obligations. Enterprise Risk Management (ERM) is a strategic approach to identify, assess, mitigate and communicate key risks to the organization. A key strategic risk for the HNHB LHIN is ensuring that HSPs deliver high quality services effectively and efficiently in compliance with accountability agreements. The HNHB LHIN will build on current processes by more rigorously applying the ERM program to SAA management.

Risk Process	SAA Management
Risk Identification (What have we discovered?)	Monthly and quarterly monitoring and assessment of financial, performance and quality data.
Risk Assessment (What does it mean?)	Determination of risk level – Green, Yellow and Red Analysis to focus on: • Performance (targets/volumes) • Surplus from HSP • System level quality outcomes
Risk Mitigation and Control (What can we do about it?)	• Capacity building • Additional performance and financial reporting • Audits • Performance Management Escalation • Operational review and governance review • Additional performance requirements • Reallocation
Risk Measurement and Communication (How do we know it worked? Who needs to know?)	• Assessment of impact • Communication to stakeholders and public

A key strategy for advancing the LHIN role in commissioning will be provider engagement. This will involve the engagement of Boards, executives, and staff to articulate new expectations and ways of providing services.

The HNHB LHIN will develop and implement an engagement plan sequenced with SAA negotiation timelines to ensure that significant performance issues are addressed at the time of agreement negotiations. The engagement plan will involve strategies to focus upon the following:

- Data quality – financial and statistical.
- Governance – ensuring a clear understanding of board's fiduciary responsibility for SAA management.
- Performance – the key organizational elements required to be in place to deliver value for money services
- Communications – clear, consistent messaging on performance improvement, the impact of not meeting SAA obligations and the negotiations involved in transfers and ceasing funding.

Successes from past year:

- The LHIN allocated its portion of the four percent community funding through a RFP process to target key priority populations. This exercise allowed the LHIN to focus funding directly on specific patient needs and link funding to high quality proposals.
- The LHIN worked with hospitals on the distribution of funding for wait time volumes for surgical procedures and DI. This collaborative effort focused on providing funding to more directly impact key objectives such as wait time reductions for patients.
- The Board approved a Performance Accountability Policy designed to articulate principles to guide performance management. This policy sets out a clear relationship between the LHIN and providers, the role of governance in performance improvement and articulates the continuum of steps to address performance challenges.

- The LHIN developed a methodology to rank agency risk in order to more proactively identify and mitigate performance and contractual issues. The framework is built on assessing risks across the following components: Contractual Compliance, Performance Indicators, and Core Financial Indicators.

PART 2: GOALS and ACTION PLANS

Goal(s):

- A Strategic Execution Framework in place to advance the integration of business planning methodologies and evidence-based decision making of a high performing organization.
- Implementation of Ministry defined "Specialty Clinics" to ensure that services provided reflect need, incorporate appropriate quality outcomes, integrate with LHIN-wide programs and reflect value for money.
- ERM framework will continue to be expanded to move the LHIN further towards a commissioning model.
- Further spread of the concept of LHIN commissioning within the LHIN office.
- HSFR will continue to evolve in alignment with the Ministry.
- Administrative costs within the health sector will continually be reduced.

Consistency with Government Priorities:

- HSFR.
- Optimize utilization of resources.
- Optimize value for money.
- Improve cost efficiency for service delivery.

Action Plans/ Interventions: **"We will deliver the following**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2014-15		**2015-16**		**2016-17**	
Examples:	Status	%	Status	%	Status	%
A Strategic Execution Framework will be developed: • Data driven root cause analysis. • Logic model. • Implementation and evaluation plan tool kit.	In Progress	50	In Progress	50		
Implementation of Ministry defined 'Specialty Clinics': • Ensure that services provided reflect population need. • Incorporate appropriate quality outcomes. • Integrate with LHIN-wide programs. • Reflect value for money.	In Progress	50	In Progress	50		

Further develop the ERM framework to look at: • Cost per case. • Comparisons between providers. • Add hospitals and CCAC into framework.	In Progress	50	In Progress	50		
ERM tool kit for the management of risk in the LTCH Sector.	Complete	100				
Further spread of the concept of LHIN commissioning within the LHIN office. Development of a Return on Investment (ROI) tool to further support Commissioning: • Development of a program/service sustainability plan should the current service/outcomes not be able to be sustained with current resources. • Ensure that all funding decisions are tied to LHIN priorities.	In Progress	50	In Progress	50		
HSFR will continue to evolve in alignment with the Ministry: • Support continual implementation of HSFR • Local Partnerships • Development of LHIN staff competency on the utilization of Health-Based Allocation Model (HBAM) and QBP as performance improvement strategies	In Progress	50	In Progress	50		
Administrative costs within the health sector will continually be reduced. • Plan has been developed to identify how best to reduce duplication in administrative support services within hospital and community sectors. o Assess current state. • Findings, conclusions and actionable recommendations.	Complete	100				

How will we measure success?

- HNHB LHIN staff, and providers are working effectively within the performance management framework.
- Clinicians actively participate in the design and delivery of efficient and effective healthcare.
- Healthcare funding provides high quality services at the best price.
- Services reflect local community needs.

- Patient experience improved through enhanced collaboration.

What are the risks/barriers to successful implementation?

- A lack of natural incentive to foster cooperation.
- Data quality is poor for some providers.
- Some providers unaware of the processes required to implement effective quality at a reasonable cost.
- Lack of clarity for not meeting SAA requirements.
- Funding processes (internal and external) less efficient.
- Program and organizational objectives lack clarity (not Specific Measurable Attainable Realistic Timely (S.M.A.R.T.) philosophy).
- Boards unclear as to their fiduciary role in SAA management.
- Significant number of providers with limited internal staff for review.
- Communications risks with possible reduction of funding or closing poor performing programs.
- Significant variation in cost per case.

For each risk/barrier, describe the plan to mitigate the risk?

- The HNHB LHIN will advance incentive systems for performance through new initiatives such as the Health Links and innovative accountability instruments (MOUs).
- The HNHB LHIN engagement plan will focus on key identified gaps including: data quality, performance management, governance and fiduciary responsibility.
- The SAA will be clear instruments for incentive and disincentive in meeting objectives.
- Effective ERM processes will rank providers based on performance, allowing staff to focus on areas of highest risk.
- A clearer, more transparent process on funding reductions will assist in communications objectives outlining the importance of patient continuity and safety.
- The HNHB LHIN will continue to leverage HSFR over the next few years to support the goals of reduced variation and cost per case.
- Shifting the focus of funding review for high risk providers will increase the efficiency of in-year allocations and transfers.

What are some of the key enablers that would allow us to achieve our goal?

- SAAs.
- Risk ranking and priority setting.
- Data quality.
- HSP engagement.
- Information scorecards.
- Staff education and engagement on auditing and value for money processes and thinking.

Additional Comments (i.e. additional information that supports the implementation/success of the goal).

4. HNHB LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2013/14 Projected Actuals	2014/15 Allocation	2015/16 Planned Expenses	2016/17 Planned Expenses
Salaries and Wages	3,689,612	3,677,781	3,677,781	3,677,781
Employee Benefits				
Hospitals of Ontario Pension Plan (HOOPP)	343,436	353,317	353,317	353,317
Other Benefits	448,375	450,438	450,438	450,438
Total Employee Benefits	**791,811**	**803,755**	**803,755**	**803,755**
Transportation and Communication				
Staff Travel	40,000	45,000	45,000	45,000
Governance Travel	12,000	13,700	13,700	13,700
Communications	48,000	58,000	58,000	58,000
Other Benefits	4,500	5,000	5,000	5,000
Total Transportation and Communication	**104,500**	**121,700**	**121,700**	**121,700**
Services				
Accommodation	334,686	347,470	347,470	347,470
Advertising		0	0	0
Banking	12,000	12,000	12,000	12,000
Community Engagement	20,000	30,000	30,000	30,000
Consulting Fees	381,144	436,047	436,047	436,047
Equipment Rentals	15,000	20,000	20,000	20,000
Governance Per Diems	83,220	83,220	83,220	83,220
LHIN Shared Services Office (LSSO) Shared Costs	660,000	510,000	510,000	510,000
Other Meeting Expenses	15,000	25,000	25,000	25,000
Other Governance Costs	6,000	6,000	6,000	6,000
Printing & Translation	25,000	45,000	45,000	45,000
Staff Development	23,000	23,000	23,000	23,000
Total Services	**1,575,050**	**1,537,737**	**1,537,737**	**1,537,737**
Supplies and Equipment				
IT Equipment	45,000	35,000	35,000	35,000
Office Supplies & Purchased Equipment	50,000	50,000	50,000	50,000
Total Supplies and Equipment	95,000	85,000	85,000	85,000
LHIN Operations: Total Planned Expense	**6,255,973**	**6,225,973**	**6,225,973**	**6,225,973**
Annual Funding Target	6,255,973	6,225,973	6,225,973	6,225,973
Variance	0	0	0	0

2013-14 is an estimate to year end based on December 31, 2013, and forecasted to March 31, 2014. Funding is shown as follows:

	2013-14	2014-15
Operations	4,916172	4,916,172
Aboriginal Community Engagement	37,500	37,500
French Language Service	106,000	106,000
Primary Care LHIN Lead	75,000	75,000
Critical Care Lead*	75,000	75,000
ER/ALC Lead*	100,000	100,000
ED Lead*	75,000	75,000
Diabetes Regional Coordination Group (DRCC) – One Time	30,000	
Diabetes Regional Coordination Group (DRCC) - Base	841,301	841,301
Total	**$6,255,973**	**$6,225,973**

* the Lead funding is shown as paid out in Consulting Fees

Note: the above does not include funding for Entite

5. HNHB LHIN Staffing and Operations: LHIN Staffing Plan Full-Time Equivalents (FTEs)

Position Title	2013/14 Estimates as of March 31, 2014 FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs	2016/17 Forecast FTEs
Chief Executive officer	1	1	1	1
Physician Lead	1	1	1	1
Director	5	5	5	5
Access to Care Advisor	4	4	4	4
Health System Transformation Advisor	6	6	6	6
Quality and Risk Managment Advisor	3	3	3	3
Finance Advisor	4	4	4	4
Health Information Advisor	3	3	3	3
Finance Analyst	1	1	1	1
Quality and Risk Management Analyst	1	1	1	1
French Language Services Coordinator	1	1	1	1
Communication Advisor	1	1	1	1
Communication Assistant	1	1	1	1
Corp Coordinator	1	1	1	1
Executive Assistant	2	2	2	2
Project Assistant	1	1	1	1
Program Assistant	1	1	1	1
Receptionist	1	1	1	1
Corporate Services Assistant	1	1	1	1
Health Links Implementation Lead	1	1	1	1
Total FTEs	**40**	**40**	**40**	**40**

6. Integrated Communications Strategy

Objectives

Business Objective:

Continuing the implementation of the SHSP over the next four years, and executing the ABP over the next year, will continue to take the HNHB LHIN on a journey to a new health care system that will dramatically improve the patient experience through quality, integration and value. This strategic aim continues to be achieved through the realization of three strategic directions:

1. Dramatically improving the patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHINs to become health system commissioners.

The HNHB LHIN's 2013-16 IHSP, five-year SHSP, and the initiatives contained in this ABP, will require a deliberate communications and engagement approach. A strong communications strategy and plan are critical to support the execution of a transformation agenda, and will support and enhance the engagement undertaken. The communication strategy and plan will need to:

- Foster an understanding of the need for health system transformation both internally and externally.
- Build support for the health system model by focusing on the benefits of the health system transformation in building an evidence-based, integrated and person-centred health care system.
- Align the HSPs to the shared vision and common direction.
- Demonstrate how organizations and individuals can participate in the success of the health system transformation.
- Mitigate communications risks of negative publicity by proactive planning of risk reduction.
- Provide information on performance and progress on the implementation – document successes and share it.

Context

- Ontario's Action Plan for Health Care, announced by the Minister in January 2012, which is consistent with the principles of the *ECFAA*, puts LHINs at the centre of health system transformation.
- The HNHB LHIN has a critical role to play in key provincial initiatives recently introduced such as HSFR, Health Links, Seniors Strategy and the expansion of QIPs into the primary and community care sectors.
- The HNHB LHIN's 2013-16 IHSP and SHSP, and the initiatives laid out in this ABP, are strategically aligned with government directions and priorities and recognize the joint accountability of the Ministry and LHINs to serve the public interest and effectively oversee the use of public funds.
- The health care system has evolved to the point where LHINs are being recognized as the local system managers who play a central leadership role in driving health system transformation.

Communications Objectives:

- To guide the communications and engagement activities of the HNHB LHIN (Board and staff) and HSP partners involved in initiatives contained in the 2014-15 ABP.
- To ensure that all stakeholders understand the role of the respective organizations to identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services based on funding available and tracking performance against signed accountability agreements.

- To provide accurate and timely information to all audiences.
- To be transparent and accountable to our shared audiences re: timelines, outcomes and opportunity for participation/feedback.

Target Audience

Depending on the situation, primary and secondary audiences will include but not be limited to:

- HSPs and Key Stakeholders (LHIN-wide, cross-LHIN and pan-LHIN):
  - HNHB LHIN HSPs – Administrative and Governance
  - Primary Care Providers including physicians
  - Patients, clients, consumers, and residents
  - Professional Associations (such as Ontario Hospital Association (OHA), Ontario Medical Association (OMA) and HAM (Hamilton Academy of Medicine))
  - Aboriginal Health Network
  - French Language Planning Entity
- Government – Administrative Leadership and Elected Officials:
  - Municipal
  - Regional
  - Provincial – including Ministry stakeholders
- General Public
  - Residents
  - Citizens Reference Panels (CRPs):
    - Broader Public
    - Aboriginal Peoples
    - French-speaking persons
  - Community Organizations
- Media:
  - Print – daily, weekly and community newspapers and publications
  - Electronic – television, radio and online
  - Social Media – Twitter, Facebook
- Other LHINs, especially neighbouring LHINs – SW, WW and Mississauga Halton (MH)
- Ministry and other ministries (as appropriate and required):
  - Health System Accountability and Performance Division – Relations and Coordination Unit (HSAPD-RCU)
  - Communications and Marketing Division (CMD)
  - Minister's Office (MO)

Strategic Approach

To support the communication strategy for the SHSP and the Annual Report the HNHB LHIN will utilize the communication strategy framework depicted below for each strategic direction.

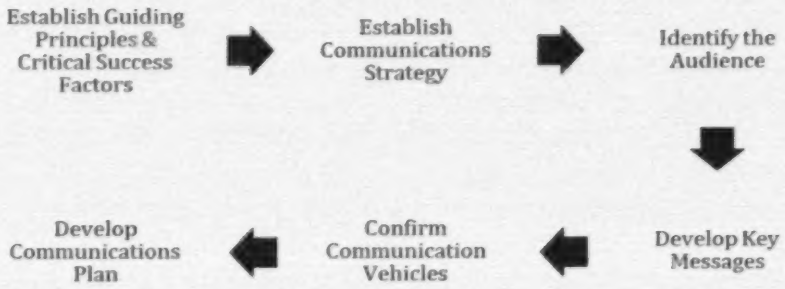
This framework will enable the LHIN to establish a clear process and will minimize risk by identifying key stakeholders, key messages and communication vehicles up front.

Effective utilization of the communication strategy will support the strategic goals of:

1. Stakeholders understanding the rationale for change, the transformational model, and the plans for implementation.
2. Leaders are engaged to champion change throughout the region.
3. The HNHB LHIN is a leader and as such the LHIN is ready and able to take ownership of the changes following implementation on a "business as usual" basis.

The communication strategy and plan is a "living document" that will be revised and updated by the HNHB LHIN to accommodate and address any changes, issues or developments.

Framework: Communications Strategy and Approach



Key Messages

- The HNHB LHIN is a key partner in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future.
- We are changing from an old system designed to treat people once they are sick, to a more coordinated, value-driven model that promotes wellness.
- The population in the HNHB LHIN is growing and aging. The rates of chronic conditions are rising.
- Current fiscal realities have resulted in even more challenges.
- The HNHB LHIN and its providers have already brought about significant and positive change in the way health services are delivered, and we must continue that work. In fact, we must aggressively build upon that work, because the status quo is neither acceptable nor sustainable.
- Everyone has an important role to play in making healthy change happen, including HSPs, the LHINs, community leaders and the public.
- The HNHB LHIN and its health care partners continue to bring about significant and positive change to ensure better patient outcomes.

- The HNHB LHIN is committed to making the experience of care more seamless and easier to navigate.
- The HNHB LHIN brings together health care partners to develop innovative, collaborative solutions leading to more coordinated, value-driven model that promotes wellness and a better patient experience.
- The HNHB LHIN is working with its partners to change from an old system designed to treat people once they are sick to a more coordinated, value-driven model that promotes wellness.
- The HNHB LHIN is the key organization in this area that brings together health care partners such as hospitals and community-based agencies to develop innovative, collaborative solutions that lead to improved access to high-quality care for all residents.

Tactics – high level, if available

The communication/engagement tactics will flow out of an overarching communications plan that will guide alignment of all audience and initiative-specific communications plans. The leadership team and staff will provide input into the communications plan, how it will be implemented, and a plan for decision making.

The following table provides a preliminary set of communications roles and responsibilities. To ensure consistency and to avoid misinformation, all communications need to be approved by the CEO and Communications team.

Target Audience	Lead	Vehicles
Provider Boards	LHIN Board	• Governance to governance sessions (G2G)
Elected officials – Municipal and Provincial – and their staff	LHIN Chair and LHIN CEO	• All party meetings • Individual MPP meetings • Constituency Staff meetings
CRP Members	LHIN CEO	• Group sessions • Twitter
General Public (including same audiences listed here)	Communications Lead/LHIN CEO	• Media • LHIN website • Newsletters • Blog • Twitter
Editorial Board meetings	Communications Lead/LHIN CEO	• Meetings, social media
Health Professions Advisory Committee (HPAC)	LHIN CEO	• Meetings
Physicians	LHIN CEO/LHIN physician lead	• Meetings/blog • Physician Newsletter • Twitter
Francophone Community	LHIN	• Meetings, media
Aboriginal Community	LHIN	• Meetings, media
Neighbouring LHINs	LHIN CEO	• Meetings, media
Ministry, HSAPD-RCU	LHIN CEO/Board Chair	• Meetings • Teleconferences
Agencies with provincial/national mandate (i.e., Canadian Mental Health Association (CMHA))	LHIN	• Meetings, media

Evaluation
Identifying critical communication success factors will enable the HNHB LHIN to more effectively identify whether stakeholder engagement activities have been successful. Critical success factors may include: • Visible senior leadership engagement and support of the project and related communications. • Senior leadership and LHIN-wide committees take visible, active roles in supporting communications and change with their teams. • Key stakeholders have a clear understanding of the 'case for change' and how they will be impacted by the implementation of the SHSP. • Health care providers across the HNHB LHIN are engaged early and frequently and can see how their participation is impacting the implementation of the Future State. • HNHB LHIN citizens are engaged by the LHIN and with the LHIN via a variety of tactics including traditional media, online media (e.g., websites, blogs) and LHIN communication vehicles (newsletters and bulletins). • The Communication program leverages a variety of communication vehicles tailored to various stakeholder groups. • Feedback mechanisms and ongoing assessment are in place to monitor the effectiveness of communication vehicles and messages, and the LHIN has the ability to make quick modifications based on shifts and lessons learned as the project unfolds.

7. Appendix

7a. Glossary of Acronyms

AAH	Aging at Home
ABI	Acquired Brain Injury
ABP	Annual Business Plan
ACP	Advanced Care Planning
AHN	Aboriginal Health Network
AHTF	Aboriginal Health Transition Fund
ALC	Alternate Level of Care
ALS	Amyotrophic Lateral Sclerosis
ALSHRS	Assisted Living Services for High Risk Seniors
AMI	Acute Myocardial Infarction
APP	Alternate Forms of Physician Payments
AR	Assess Restore
ASIST	Applied Suicide Intervention Skills Training
BCHS	Brant Community Healthcare System
BSO	Behavioral Supports Ontario
BSS	Behavioral Supports Services
CAMH	Centre For Addictions and Mental Health
CBHSC	Community-Based Health Service Capacity
cGTA	Connecting Greater Toronto Area
cSWO	Connecting South Western Ontario
cWO	Connecting Western Ontario
CC	Complex Care
CCO	Cancer Care Ontario
CCAC	Community Care Access Centres
CCIM	Community Care Information Management
CCN	Cardiac Care Network
CCRS	Continuing Care Reporting System
CDPM	Chronic Disease Prevention Management
CDSM	Chronic Disease Self-Management
CE	Community Engagement
CEO	Chief Executive Officer

CHC	Community Health Centres
CHF	Congestive Heart Failure
CHRIS	Client Health and Related Information System
CHSEE	Continuing Health Sciences Education Event
CIHI	Canadian Institute for Health Information
CKD	Chronic Kidney Disease
CMG	Case Mix Group
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outreach Team
CPI	Clinical Program Integration
CQA	Common Quality Agenda
CRCS	Canadian Red Cross Society
CREMS	Community Referrals by Emergency Medical Services
CRP	Citizens Reference Panel
CSP	Clinical Services Plan
CSCHN	Centre de Santé Communautaire de Hamilton-Niagara
CSRM	Community Stroke Rehabilitation Model
CSRSN	Central South Regional Stroke Network
CSS	Community Support Services
CSSN	Community Support Services of Niagara
CT	Computed Tomography
CTAS	Canadian Triage Acuity Scale
CYMHA	Children and Youth Mental Health and Addictions
DAD	Discharge Abstract Database
DAP	Diagnostic Assessment Program
DART	Dates Affecting Readiness to Treat
DEP	Diabetes Education Program
DI	Diagnostic Imaging
DI-r	Diagnostic Imaging Repository
DRCC	Diabetes Regional Coordinating Centre
DD	Developmental Disability
ehealth	Electronic Healthcare
ECFAA	Excellent Care for All Act
ED	Emergency Department
EIS	Early Intervention Screening

EMRs	Electronic Medical Records
EMS	Emergency Medical Services
ERM	Enterprise Risk Management
ESAS	Edmonton System Assessment System
ESC	Erie St. Clair
ESSC	Emergency Services Steering Committee
ETP	Emergent Transfer Plan
EVAR	Endovascular Aneurysm Repair
FHT	Family Health Team
FL	French Language
FLHS	French Language Health Services
FLIP	French Language Implementation Plan
FLPE	French Language Planning Entity
FLS	French Language Services
FLSA	French Language Services Act
FLT	French Language Training
FP	Falls Prevention
FTE	Full-Time Equivalent
FY	Fiscal Year
GAIN	Geriatric Access and Integration Network
GAIT	Geriatric Assessment Intervention Team
GIMRAC	General Internal Medicine Rapid Access Clinic
GRH	Grand River Hospital
GTA	Greater Toronto Area
GTG	Governance to Governance
HCC	Healthcare Consent
HHR	Health Human Resources
HHSC	Hamilton Health Sciences Corporation
HNHB	Hamilton Niagara Haldimand Brant
HOBIC	Health Outcomes for Better Information and Care
HOOPP	Hospitals of Ontario Pension Plan
HPCN	Hospice Palliative Care Network
HPAC	Health Professionals Advisory Committee
HQO	Health Quality Ontario
HR	Human Resources

HRLMP	Hamilton Regional Laboratory Medicine Program
HRM	Hospital Report Manager
H-SAA	Hospital Service Accountability Agreement
HAS-RCU	Health System Accountability and Performance Division – Relations and Coordination Unit
HSFR	Health System Funding Reform
HSP	Health Service Provider
IAR	Integrated Assessment Record
ICES	Institute for Clinical Evaluative Sciences – Ontario
ICL	Integrated Community Lead
ICSP	Integrated Cancer Screening Plan
IDS	Integrated Decision Support
IHIU	Integrated Heart Investigation Unit
IHSP	Integrated Health Service Plan
IMRA	Internal Medicine Rapid Assessment
IOCP	Integrated Orthopaedic Capacity Plan
IPC	Inter-professional Care
Inter RAI CHA	interRAI (Resident Assessment Instrument) CHA – Community Health Assessment
IRTP	Integrated Radiation Treatment Program
IT	Information Technology
JAAP	Joint Annual Action Plan
JBH	Joseph Brant Hospital
JCC	Juravinski Cancer Centre
LHIN	Local Health Integration Network
LHSIA	Local Health System Integration Act
L-SAA	Long-Term Homes Service Accountability Agreement
LICO	Low Income Cut-Off
LOS	Length of Stay
LSSO	LHIN Shared Services Office
LTC	Long-Term Care
LTCH	Long-Term Care Homes
MAC	Medical Advisory Committee
MH	Mental Health
MH and A	Mental Health and Addictions
Minister	Minister of Health and Long-Term Care
Ministry	Ministry of Health and Long-Term Care

M-LAA	Ministry-LHIN Accountability Agreement
M-LPAA	Ministry-LHIN Performance Accountability Agreement
MOU	Memorandum of Understanding
MPCC	Mobile Primary Care Clinic
MPP	Member of Provincial Parliament
MRI	Magnetic Resonance Imaging
M-SAA	Multi-Sector Accountability Agreement
MSSU	Medical Short Stay Units
NACRS	National Ambulatory Care Reporting System
NEO	North East Ontario
NH	North Hamilton
NHS	Niagara Health System
NLOT	Nurse Led Outreach Team
NP	Nurse Practitioner
NRS	National Rehabilitation Reporting System
OACCAC	Ontario Association of Community Care Access Centres
OBSP	Ontario Breast Screening Program
OCAN	Ontario Common Assessment of Need
ODIT	Ontario Diagnostic Imaging Terminology
ODS	Ontario Diabetes Strategy
OECD	Organization of Economic Cooperation and Development
OHA	Ontario Hospital Association
OHIP	Ontario Health Insurance Program
OLIS	Ontario Laboratory Information System
OMHRS	Ontario Mental Health Reporting System
ORN	Ontario Renal Network
OTN	Ontario Telemedicine Network
P4R	Provincial Pay for Results
PAG	Planning Advisory Group
PCI	Percutaneous Coronary Intervention
PD	Peritoneal Dialysis
PE	Planning Entity
PHIPA	Personal Health Information Privacy Act
PIP	Process Improvement Plan
PMO	Program Management Office

PPS	Palliative Performance System
PSDA	Plan-Do-Study-Acts
PwC	Pricewaterhouse Coopers
QGC	Quality Guidance Council
QBP	Quality Based Procedures
QI	Quality Improvement
QIP	Quality Improvement Plan
R2T2	Rapid Response Transition Team
RAZ	Rapid Assessment Zones
RCP	Regional Cancer Program
RFP	Request for Proposal
RIS	Regional Informatics Strategy
RM&R	Resource Matching & Referral
RMON	Regional Municipality of Niagara
ROI	Return on Investment
ROS	Regional Oncology System
RRTT	Rapid Response Transitional Care Team
SAAs	Service Accountability Agreements
SFH	Senior Friendly Hospital
SGS	Specialized Geriatric Services
SHSP	Strategic Health System Plan
SSR	Slow Stream Rehab
SJHH	St. Joseph's Healthcare Hamilton
S.M.A.R.T.	Specific Measurable Attainable Realistic Timely
SW	South West
SWO	South West Ontario
TALK	Tell, Ask, Listen and Keep Safe
TC	Toronto Central
TIA	Transient Ischemic Attack
TJR	Total Joint Replacement
UCC	Urgent Care Centre
VP	Vice President
VSM	Value Stream Mapping
WASP	Walk Away Specimen Processing
WFCC	Walker Family Cancer Centre

WTIS	Wait Time Information System
WW	Waterloo Wellington
WWHN	Waterloo Wellington Hamilton Niagara
YTD	Year To Date